State of California

Medi-Cal Managed Care Plans

RESULTS
of the
HEDIS® 2002 PERFORMANCE MEASURES
for
MEDI-CAL MANAGED CARE MEMBERS

FEBRUARY 2003

CALIFORNIA DEPARTMENT
OF HEALTH SERVICES

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HSAG
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CONTENTS

1. Executive Summary

2. Keys to Getting the Most From This Report

3. Pediatric Care

4. Women's Care

5. Living with Illness

6. Systemic Issues

7. Appendices

FIGURES AND TABLES

1. Executive Summary

2. Keys to Getting the Most From This Report

3. Pediatric Care

4. Women's Care

5. Living with Illness

7. Appendices

Overview

The California Department of Health Services (DHS) currently contracts with 22 Medi-Cal managed care plans that provide services to more than 2.9 million Medi-Cal members. To evaluate the performance of these managed care plans, DHS introduced an annual quality measurement program using nationally recognized health care measures. The Health Plan Employer Data and Information Set (HEDIS®)[1] is the set of performance measures recognized as the industry standard to compare and measure health plan performance. HEDIS is developed and maintained by the National Committee for Quality Assurance (NCQA).

DHS selected seven HEDIS measures from the standard Medicaid set as the DHS External Accountability Set for evaluating performance of the Medi-Cal managed care plans. DHS has contracted with Health Services Advisory Group, Inc. (HSAG), as the External Quality Review Organization (EQRO), to objectively analyze Medi-Cal managed care plan HEDIS results and to evaluate current performance levels relative to national benchmarks. Some health plans have more than one geographic contract area and, for the purposes of performance measurement and evaluation, the results of the 30 contract-specific areas are reported as 30 individual Medi-Cal managed care plans.[2]

Performance levels have been established for all of the measures in the DHS External Accountability Set. The performance levels have been set at specific, attainable rates and are based on national benchmarks. Health plans meeting the High Performance Level (HPL) exhibit rates among the top in the nation. The Minimum Performance Level (MPL) has been set to identify health plans in the greatest need of improvement. Section 2 ("Keys to Getting the Most From This Report") discusses these performance levels in more detail.

HSAG has categorized the DHS External Accountability Set of measures by three different dimensions of care: Pediatric Care, Women's Care, and Living with Illness. These dimensions reflect important groupings, and are similar to the dimensions model used by the Foundation for Accountability (FACCT). This approach is designed to encourage the consideration of the DHS External Accountability Set as a whole rather than in isolation, and to think about the strategic and tactical changes required to improve overall performance.

This report analyzes Medi-Cal managed care HEDIS results in several ways. For each of the three dimensions of care:

1. A performance analysis examines the 2002 Medi-Cal managed care overall averages relative to 2001 overall averages and to the NCQA 2001 national Medicaid averages.
2. A health plan ranking analysis provides an overview of the relative performance of the Medi-Cal managed care plans.
3. A data collection analysis evaluates the potential impact of data collection methodology on the reported rates.
4. A health plan trend table illustrates Medi-Cal managed care plans' reported rates for the past three years (or the past two years if the measure was introduced into the DHS External Accountability Set at a later date).

[1] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[2] For a complete list of the 22 Medi-Cal managed care plans and their 30 health plan contract-specific areas (serving 21 counties), see "Table 2-1—2002 Medi-Cal Managed Care Plans: Contract-Specific Area Names and Abbreviations" on page 2-2. For the example described in the text above, the table lists Kaiser Foundation Health Plan, Inc. (Sacramento) and Kaiser Foundation Health Plan, Inc. (San Diego) as the two contract-specific areas for the Kaiser Foundation Health Plan, Inc. Medi-Cal managed care plan. The table also lists Kaiser (GMC-North) and Kaiser (GMC-South) as abbreviated plan names used to identify these contract-specific areas, treated as separate plans, in this report.

Additionally, Section 6 of the report provides a systemic analysis that considers global issues faced by Medi-Cal managed care plans in the calculation of rates for these measures.

Key Findings

Medi-Cal HEDIS Rates Improved

- Since 2000, the Medi-Cal managed care plans have shown steady improvement in the rates for five of the seven HEDIS measures in the DHS External Accountability Set. The Medi-Cal managed care averages for *Adolescent Well-Care Visits* and *Use of Appropriate Medications for People with Asthma* have remained constant, slightly below the national Medicaid averages.
- In 2002, for the first time, the Medi-Cal managed care *Postpartum Care Visit* average exceeded the national Medicaid average.
- The HEDIS 2002 results show that 14.9 percent were above the HPLs, and only 4.8 percent of all managed care plan rates were below the MPLs for the measures in the DHS External Accountability Set. These are improvements of 4.3 and 6.2 percentage points, respectively, over 2001.

Comprehensive Quality Improvement Programs Positively Affected Reported Rates

- CalOptima implemented successful strategies that improved its rate for *Adolescent Well-Care Visits* from 22.7 percent in 1999 to 43.3 percent in 2002. These strategies included a member incentive of a gift certificate.
- Contra Costa Health Plan initiated an Internal Quality Improvement Program (IQIP) on adult asthma management in 1999. In the 2002 reporting year, Contra Costa Health Plan showed the largest year-to-year difference in its rate for the *Use of Appropriate Medications for People with Asthma* measure, with a rate increase of 35.7 percentage points from 49.6 percent to 85.3 percent.
- The rates for Blue Cross also showed strong improvement in the *Use of Appropriate Medications for People with Asthma*. Blue Cross distributed Asthma Clinical Practice Guidelines to primary care practitioners (PCPs), conducted one-on-one member/pharmacist consultation, and distributed asthma kits to its asthmatic members.
- Santa Barbara Health Initiative's disease management program for diabetes has led to its highest reported rates for *Eye Exams for People with Diabetes*.
- Santa Barbara Health Initiative's Comprehensive Perinatal Services Program consistently has led to its highest reported rates for *Prenatal and Postpartum Care*.

Improvement Demonstrated in Medi-Cal Managed Care Plans' HEDIS Reporting Processes

- This was the first year every Medi-Cal managed care plan was able to report on every measure in the DHS External Accountability Set. None of the Medi-Cal managed care plans received Not Report (NR) audit designations in 2002.

Administrative Data More Complete – Improvement Still Needed

- The majority of the Medi-Cal managed care plans' rates for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life,* and *Adolescent Well-Care Visits* were derived from

administrative data, with very little increase in the overall rate based on medical record review. This suggests the administrative data are largely complete for these two HEDIS measures. *Childhood Immunization Status, Well-Child Visits in the First 15 Months of Life, Timeliness of Prenatal Care, Postpartum Care Visits* and *Eye Exams for People with Diabetes* still require medical record review to achieve the best rates possible.

Incentive Programs to Improve Encounter Data Submission Resulted in Higher 2002 Reported Rates

- Many health plans used incentive programs to encourage better reporting of encounter data. For example, Alameda Alliance for Health's rate for *Adolescent Well-Care Visits* improved from 32.9 percent in 2001 to 40.0 percent in 2002. Data reporting was improved after the health plan began paying providers on a fee-for-service basis in addition to the providers' capitation rate.

Alternative Data Sources Resulted in Improved 2002 Rates

- Health plans used alternative data sources to gather information. UCSD Health Plan obtained additional immunization data from the county registry and increased its 2002 *Childhood Immunization Status, Combination 1* rate 27.2 percentage points to 61.4 percent.

Performance Summary

A summary of the Medi-Cal managed care averages from 2000 to 2002 is presented below in Table 1-1. All of the averages for 2002, with the exception of *Adolescent Well-Care Visits* and *Use of Appropriate Medications for People with Asthma*, were above the NCQA 2001 national Medicaid averages.

Table 1-1—Aggregate HEDIS Results (2000 – 2002)

DHS External Accountability Set	Medi-Cal Managed Care Averages			Medi-Cal Managed Care Weighted Averages*			NCQA National Medicaid Averages		Minimum Performance Level (MPL)**	High Performance Level (HPL)**
	2000	2001	2002	2000	2001	2002	2000	2001		
Childhood Immunization Status Combination 1	53.8	57.0	62.2	52.3	55.6	59.6	51.2	56.0	41.8	69.3
Childhood Immunization Status Combination 2	44.3	51.5	59.2	44.3	50.5	56.9	38.0	46.7	27.6	55.9
Well-Child Visits in the First 15 Months of Life (Six or More Visits)	32.9	37.6	41.3	30.2	38.5	41.4	30.2	33.8	18.1	57.9
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life	56.7	56.4	59.6	50.8	54.2	56.4	49.0	50.5	38.9	68.2
Adolescent Well-Care Visits	29.9	26.9	28.2	26.7	25.8	26.9	28.0	30.2	19.3	44.4
Timeliness of Prenatal Care	NA	69.1	73.4	NA	66.3	72.2	NA	70.9	46.0	79.5
Postpartum Care	46.5	46.8	53.6	46.7	46.6	52.8	48.0	47.9	34.5	61.0
Use of Appropriate Medications for People with Asthma (Combined Rate)	NA	54.5	54.6	NA	54.5	54.6	50.4	57.1	44.9	64.9
Eye Exams for People With Diabetes	53.1	58.1	62.0	52.2	54.0	61.4	41.0	41.8	26.6	61.1

* Weighted averages are based on each health plan's eligible population.

**The MPLs and HPLs for each measure were defined as the NCQA 2000 national Medicaid 25th and 90th percentiles, respectively. The measures *Timeliness of Prenatal Care* and *Postpartum Care* did not have available percentiles in 2000, and therefore the HPL was established as the Medi-Cal managed care average plus one standard deviation and the MPL was established as the Medi-Cal managed care average minus one standard deviation.

Table 1-2—Medi-Cal Managed Care Plans Below the MPLs or Above the HPLs for HEDIS 2000, 2001 and 2002

Medi-Cal Managed Care Plan	CI	WI	WC	WA	TPC	CAD	DIB	ASM
Alameda Alliance for Health								▼
Blue Cross (CP)			▲		▲			▲
Blue Cross (GMC-North)		▲			▲			
Blue Cross (GMC-South)				▼▼	▲▲			
Blue Cross (Stanislaus)				▼	▲			
Blue Cross (Tulare)		▼			▲	▲		
CalOptima	▲	▼			▲	▲		▲
Central Coast Alliance for Health							▲	
Community Health Group	▲	▼						
Contra Costa Health Plan	▲▲		▲		▲▲	▼		▲
Health Net (CP)					▼	▼		▼
Health Net (GMC-North)					▼	▼		
Health Net (GMC-South)	▲				▼	▼▼		
Health Plan of San Joaquin	▼							▲
Health Plan of San Mateo						▲▲▲		▲
Inland Empire Health Plan								
Kaiser (GMC-North)	▲	▲▲▲						
Kaiser (GMC-South)			▲	▲▼	▲▲	▲		▼▼
Kern Family Health Care								▲
L.A. Care Health Plan		▼▼		▼▼▼				▼
Molina Healthcare of California	▼	▼▼				▼▼▼		
Molina Healthcare (GMC-North)	▼							
Partnership Healthplan						▲		▲
San Francisco Health Plan		▲▲	▲					
Santa Barbara Health Initiative	▲▲▲	▲▲▲			▲▲	▲▲▲	▲▲	
Santa Clara Family Health Plan					▲▲			
Sharp Health Plan	▼	▼▼	▲		▼	▼▼		
UCSD Health Plan	▼	▼		▼	▲	▲		▲▲
Universal Care		▼		▼▼		▼		
Western Health Advantage	▼							

▼ **Below MPL for 2000** ▼ **Below MPL for 2001** ▼ **Below MPL for 2002**

▲ **Above HPL for 2000** ▲ **Above HPL for 2001** ▲ **Above HPL for 2002**

CI =	Childhood Immunization Status Combination 1	TPC =	Timeliness of Prenatal Care
WI =	Well-Child Visits in the First 15 Months of Life	CAD =	Postpartum Care (formerly Check-ups After Delivery)
WC =	Well-Child Visits in 3rd, 4th, 5th and 6th Year of Life	DIB =	Eye Exams for People with Diabetes
WA =	Adolescent Well-Care Visits	ASM =	Use of Appropriate Medications for People with Asthma

	Plans Below MPLs		Plans Above HPLs	
	Number	Percent	Number	Percent
2000	17	8.1	10	4.8
2001	27	12.9	22	10.5
2002	10	4.8	31	14.8

Key Recommendations

Initiate or Continue Perinatal Quality Improvement Programs

- The Medi-Cal managed care plans should be encouraged to implement or continue perinatal quality improvement programs. The highest reported rates were seen in the Medi-Cal managed care plans with these programs and reinforce the value of these quality improvement efforts.

Begin or Expand Comprehensive Diabetic Disease Management Programs

- The County Organized Health System (COHS) health plans should maintain or begin disease management programs with a focus on diabetes. The large improvement seen in the COHS health plans with focused diabetes disease management activities reinforces the value of these efforts.

Develop or Maintain Asthma Quality Improvement Programs

- The Medi-Cal managed care plans should be encouraged to continue their asthma disease management programs. The large improvement seen in the managed care plans with focused asthma disease management activities reinforces the value of these efforts.

Utilize All Available Administrative Data Sources

- Alternative administrative data sources include the Provider Manual (PM)–160 data, immunization data from the county registry and internal plan databases (e.g., utilization management and disease management databases). While these additional administrative sources must be validated, Medi-Cal managed care plans that have used multiple data sources, such as immunization data from the county registry, have shown increases in their HEDIS rates.

Consider Incentives for Providers and Members

- Provider incentives have been shown to improve encounter data submission. Increased administrative data is beneficial for health plans since the number of medical records needed for HEDIS reporting may be reduced. Medical record pursuit and review is time consuming, labor intensive, and expensive. The associated savings by using administrative data may be redirected toward measures for which medical record review may have a greater impact. Similarly, the data suggest member incentives have increased the quantity of services provided and boosted HEDIS rates.

2. Keys to Getting the Most From This Report

Introduction

This section is designed as a guide to assist with interpreting and understanding the data presented in this report. Brief descriptions highlighting the key components of the technical aspects of HEDIS data collection and analysis are provided. Basic information describing sample sizes and sampling errors is also included as a reference.

Medi-Cal Managed Care Plans

Some of the 22 Medi-Cal managed care plans have more than one geographic contract area. For performance measurement and evaluation, DHS reports results of the 30 contract-specific areas as 30 individual Medi-Cal managed care plans. For example, Kaiser Foundation Health Plan, Inc. has two contract-specific areas (Sacramento and San Diego). Results were reported separately for these two areas as Kaiser (GMC-North) and Kaiser (GMC-South). For Commercial Plan (CP) health plans participating in more than one county (e.g., Blue Cross of California), the report only shows one result. Table 2-1 on page 2-2 lists the names of Medi-Cal managed care plan contract-specific areas and the abbreviated health plan names used to refer to them in this report.

Table 2-1—2002 Medi-Cal Managed Care Plans: Contract-Specific Area Names and Abbreviations

	Contract-Specific Areas for Medi-Cal Managed Care Plans	Abbreviated Health Plan Names Used in This Report
1.	Alameda Alliance for Health	Alameda Alliance for Health
2.	Blue Cross of California	Blue Cross (CP)
3.	Blue Cross of California (Sacramento)	Blue Cross (GMC-North)
4.	Blue Cross of California (San Diego)	Blue Cross (GMC-South)
5.	Blue Cross of California (Stanislaus)	Blue Cross (Stanislaus)
6.	Blue Cross of California (Tulare)	Blue Cross (Tulare)
7.	CalOptima	CalOptima
8.	Central Coast Alliance for Health	Central Coast Alliance
9.	Community Health Group	Community Health Group
10.	Contra Costa Health Plan	Contra Costa Health Plan
11.	Health Net	Health Net (CP)
12.	Health Net (San Diego)	Health Net (GMC-South)
13.	Health Net (Sacramento)	Health Net (GMC-North)
14.	Health Plan of San Joaquin	Health Plan of San Joaquin
15.	Health Plan of San Mateo	Health Plan of San Mateo
16.	Inland Empire Health Plan	Inland Empire Health Plan
17.	Kaiser Foundation Health Plan, Inc. (Sacramento)	Kaiser (GMC-North)
18.	Kaiser Foundation Health Plan, Inc. (San Diego)	Kaiser (GMC-South)
19.	Kern Family Health Care	Kern Family Health Care
20.	L.A. Care Health Plan	L.A. Care Health Plan
21.	Molina Healthcare of California	Molina Healthcare of California
22.	Molina Healthcare of California (Sacramento)	Molina Healthcare (GMC-North)
23.	Partnership Healthplan of California	Partnership Healthplan
24.	San Francisco Health Plan	San Francisco Health Plan
25.	Santa Barbara Health Initiative	Santa Barbara Health Initiative
26.	Santa Clara Family Health Plan	Santa Clara Family Health Plan
27.	Sharp Health Plan	Sharp Health Plan
28.	University of California at San Diego Health Plan	UCSD Health Plan
29.	Universal Care	Universal Care
30.	Western Health Advantage	Western Health Advantage

Medi-Cal Managed Care HEDIS Measures

HEDIS includes a standard set of measures that can be reported by health plans nationwide. The seven HEDIS performance measures analyzed in this report, referred to as the DHS External Accountability Set, were selected by DHS with significant input from the contracted health plans and HSAG. The measures selected for 2002 were the same as those selected in 2001. In 2002, Medi-Cal managed care plans in 30 geographic contract areas reported the DHS External Accountability Set measures, resulting in the rates included in this report. The measures are as follows:

- *Childhood Immunization Status, Combinations 1 and 2*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* (Non-COHS health plans only)
- *Adolescent Well-Care Visits*
- *Prenatal and Postpartum Care*
- *Use of Appropriate Medications for People with Asthma (Combined Rate)*
- *Eye Exams for People with Diabetes* (COHS health plans only)

Eye Exams for People with Diabetes rates were reported by the five COHS health plans in place of the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* measure. This approach was taken because there is a significant difference in the average age of the COHS population compared to other health plans, and the diabetes measure better reflects the large number of COHS members with chronic illness.

The following five COHS health plans reported *Eye Exams for People with Diabetes* rates:

- CalOptima;
- Central Coast Alliance;
- Health Plan of San Mateo;
- Partnership Healthplan; and
- Santa Barbara Health Initiative.

Dimensions of Care

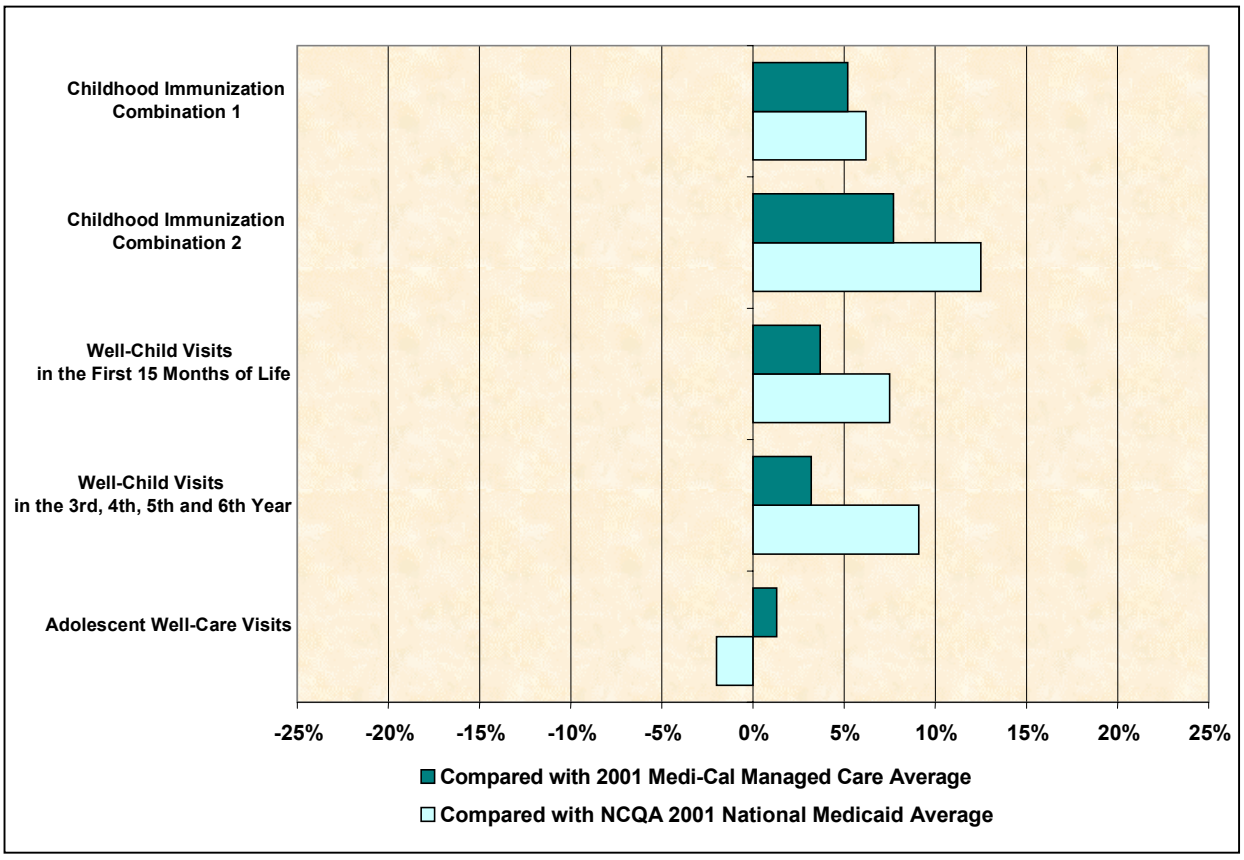
HSAG examined three different dimensions of care for Medi-Cal managed care members: Pediatric Care; Women's Care; and Living with Illness. These dimensions reflect important groupings similar to the model used by the Foundation for Accountability (FACCT). This approach is designed to encourage health plans to consider the DHS External Accountability Set as a whole rather than each measure in isolation, and to think about the strategic and tactical changes required to improve overall performance and affect the care of members.

A Medi-Cal managed care overall average rate comparison graph is presented at the beginning of the section for each dimension of care. The example below shows how to interpret this graph. Figure 2-1 provides a visual display of the 2002 Medi-Cal managed care averages compared with the previous year and with national Medicaid averages.

Follow these guidelines to interpret the graph:

- The light bars indicate the difference in percentage points between the 2002 Medi-Cal managed care average and the 2001 Medi-Cal managed care average.
- The dark bars indicate the difference in percentage points between the 2002 Medi-Cal managed care average and the NCQA 2001 national Medicaid average.
- The center axis represents 0 percent difference.
- Bars to the right of the center axis (0 percent difference) indicate better comparative performance.
- Bars to the left of the center axis indicate poorer comparative performance.

Figure 2-1—2002 Medi-Cal Managed Care
Overall Average Rate Comparison Example Graph



Performance Levels

For each of the HEDIS measures, DHS established minimum performance levels (MPLs) and high performance levels (HPLs). The MPLs and HPLs for each measure were defined as the NCQA 2000 national Medicaid 25th and 90th percentiles, respectively. The measures *Timeliness of Prenatal Care* and *Postpartum Care* did not have available percentiles in 2000, and therefore the HPL was established as the Medi-Cal managed care average plus one standard deviation and the MPL was established as the Medi-Cal managed care average minus one standard deviation. The 2000 performance levels are effective for three years (through 2002) to enable the health plans to compare performance against a consistent benchmark while quality improvement interventions take effect. In future reporting years, updated benchmarks and percentiles will be used.

Rates and Averages Used in this Report

The principal measure of Medi-Cal managed care performance is the overall average rate. Average rates are calculated as the sum of all numerators over the sum of all denominators for all health plans reporting a rate, adjusted for a maximum denominator size of 432. Medi-Cal managed care plans with more than 432 sample cases in the denominator—that is, health plans that used the administrative method for hybrid measures—were adjusted to 432 in the calculation of the Medi-Cal managed care average. See Appendix E for details.

The use of a weighted average, based on the health plan's eligible population for that measure, provides an additional view of the overall Medi-Cal managed care average. Weighting the rate by the health plan eligible population ensures rates for health plans with more members have a greater impact on the overall Medi-Cal managed care average. For the administrative-only measure (i.e., *Use of Appropriate Medications for People with Asthma—Combined Rate*), the average equals the weighted average because there is no sample; the entire eligible population is used for every health plan so no population adjustment is needed.

The *Prenatal and Postpartum Care* measure was a new measure in 2001. This measure comprises two numerators. The *Postpartum Care* numerator remained unchanged from previous years but the *Timeliness of Prenatal Care* numerator was new in 2001, hence no 2000 NCQA average is available.

NCQA national Medicaid averages for 2001 are simple averages, or means, for the measures and are shown for comparison only.

Interpreting Results

Each dimension of this report is structured in a similar format, beginning with a discussion of the importance of the HEDIS measure to the Medi-Cal managed care population, followed by the analysis of measures in that dimension, and ending with a review of the trends and an explanation of quality improvement efforts implemented for the measure.

As expected, HEDIS results differ to a greater or lesser extent between Medi-Cal managed care plans and even across measures for the same plan.

There are four questions that should be asked when examining these data:

1. How accurate are the results?
2. How do Medi-Cal managed care averages and managed care plan rates compare with national benchmarks?
3. How are Medi-Cal managed care plans doing overall?
4. How can Medi-Cal managed care plans determine which data collection method is the most advantageous for reporting HEDIS rates?

(1) How accurate are the results?

DHS required all of the Medi-Cal managed care plans to have their results audited by an NCQA-licensed audit organization. HSAG, an NCQA-licensed auditing firm, conducted the audits using the standardized methodology specified by NCQA. Therefore, any rate included in this report is not materially biased. Three Medi-Cal managed care plans—Blue Cross, Contra Costa Health Plan, and Molina Healthcare of California—chose other NCQA-licensed auditing firms, since they had previous relationships with these firms. DHS allowed the plans to maintain this continuity, and provided their audited rates to HSAG for this report. Common audit issues are discussed in detail in Section 6 of this report.

The NCQA HEDIS protocol is designed such that, when using the hybrid methodology, results will be within a +/- 5 percent sampling error at a 95 percent confidence level.

(2) How do Medi-Cal managed care overall averages and managed care plan rates compare with national benchmarks?

For each dimension, a summary analysis examines the 2002 Medi-Cal managed care overall averages relative to the NCQA 2001 national Medicaid average and the 2001 Medi-Cal managed care averages. For each measure, a health plan ranking analysis provides a view of the relative performance of the individual 2002 Medi-Cal managed care plan rates compared with the NCQA 2001 national Medicaid average and the 2001 Medi-Cal managed care averages. The analytical graphs also indicate the HPL and MPL for the measure.

(3) How are Medi-Cal managed care plans doing overall?

A health plan trend figure illustrates Medi-Cal managed care plan reported rates for each measure for the last three years. Two measures (*Use of Appropriate Medications for People with Asthma* and *Prenatal and Postpartum Care*) were new for the Medi-Cal managed care plans in 2001 and, therefore do not have comparative data from 1999 or 2000.

HSAG contacted each of the Medi-Cal managed care plans that showed either a substantial increase or decrease in rates between 2001 and 2002 to discuss and document the quality improvement efforts the plans had made. HSAG has incorporated the health plans' comments into this report.

(4) How can Medi-Cal managed care plans determine which data collection method is the most advantageous for reporting HEDIS rates?

Health plans should consider the cost/benefit ratio of pursuing medical records. Medical record pursuit and review is time consuming, labor intensive, and expensive. The associated savings by using administrative data may be redirected toward measures for which medical record review may have a greater impact.

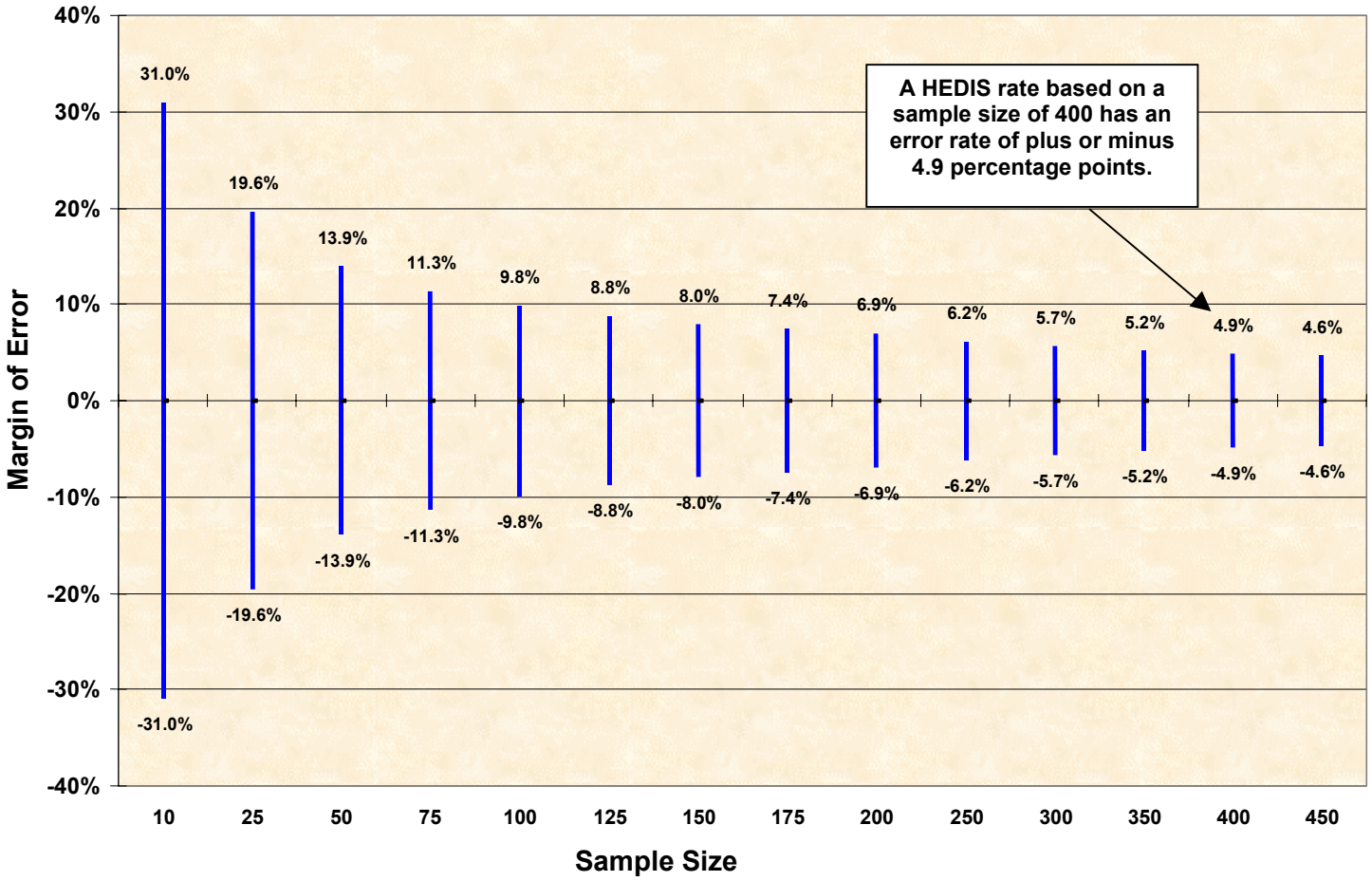
To aid in this decision, each hybrid measure is shown in a bar graph depicting the proportion of the rate derived from administrative (Admin) data and the proportion derived from medical record review (MRR).

Understanding Sample Error

Correct interpretation of results for measures collected using the hybrid methodology requires an understanding of sampling error. It is rarely possible logistically or financially to do medical record review for the entire eligible population for a given measure. Measures collected using the hybrid method include only a sample from the population and use statistical techniques to maximize the probability that the sample results reflect the experience of the entire eligible population.

For results to be generalized to the entire population, the process of sample selection must give everyone in the eligible population an equal chance of being selected. The HEDIS hybrid methodology prescribes a systematic sampling process selecting at least 411 members of the eligible population. Figure 2-2 below shows that if 411 health plan members are included in a measure, the margin of error is approximately ± 4.9 percent. The smaller the sample size, the larger the sample error.

Figure 2-2—Relationship of Sample Size to Sample Error



Introduction

Pediatric primary health care is essential to preventing, recognizing, and treating health conditions that could have significant developmental consequences for children and adolescents. The need for appropriate immunizations and health check-ups has even greater importance and significance at younger ages. For example, abnormalities in growth, hearing, and vision, when undetected in the toddler age group, affect all future learning opportunities and experiences. Early detection of developmental difficulties provides the greatest opportunity for intervention and resolution so that children continue to grow and learn free from any health-related limitations.

The Pediatric Care dimension encompasses four HEDIS measures:

- Childhood Immunization Status, Combinations 1 and 2;
- Well-Child Visits in the First 15 Months of Life;
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life (Combined Rate); and
- Adolescent Well-Care Visits.

The following sections analyze rankings and performance, data collection methodology, and trends for Medi-Cal managed care plan rates that comprise the DHS External Accountability Set.

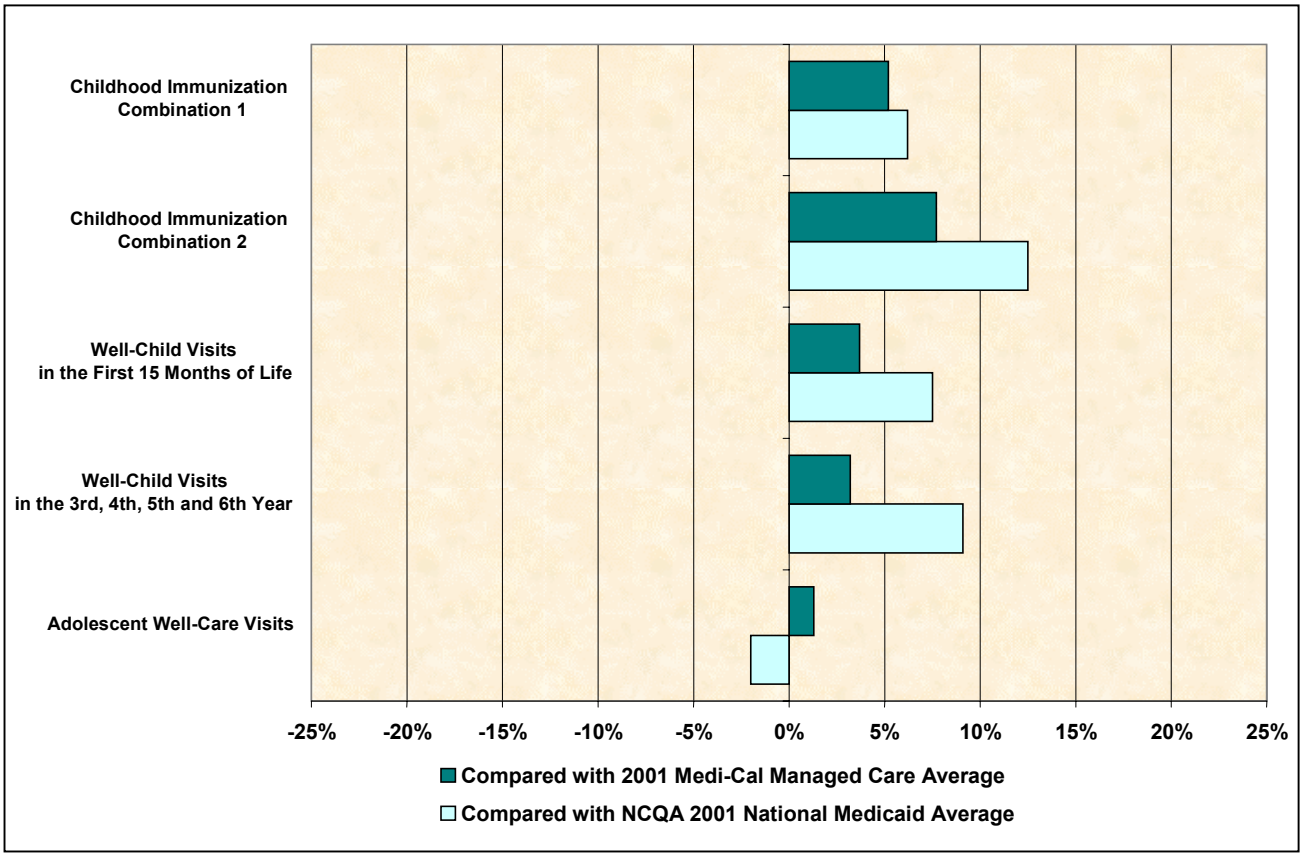
Overall Average Rate Comparison for Pediatric Care

Figure 3-1 on the following page illustrates these points:

- **The Medi-Cal managed care plans have improved their rates for all but one of the Pediatric Care measures.** All of the Medi-Cal managed care plans were able to report these measures in 2002, and the majority of reported rates were above the national Medicaid averages.
- ***Childhood Immunization Status, Combination 1* rates were above the NCQA 2001 national Medicaid average and appear to be improving in the Medi-Cal managed care population.** Two-thirds of the Medi-Cal managed care plans had childhood immunization rates above the NCQA 2001 national Medicaid average. Five Medi-Cal managed care plans reported rates above the HPL of 69.3 percent. These immunization rates have consistently increased since 2000.
- ***Childhood Immunization Status, Combination 2* rates were above the NCQA 2001 national Medicaid average and appear to be improving in the Medi-Cal managed care population.** Ninety percent of the Medi-Cal managed care plans had childhood immunization rates above the NCQA 2001 national Medicaid average. Twenty Medi-Cal managed care plans reported rates above the HPL of 55.9 percent. These immunization rates have consistently increased since 2000.
- **The 2002 Medi-Cal managed care average for well-child visits were above the NCQA 2001 national Medicaid average.** Indeed, for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life*, 88.0 percent of the Medi-Cal managed care plans[3] exceeded the NCQA 2001 national Medicaid average of 50.5 percent. Additionally, the well-child visit rates increased over the Medi-Cal managed care averages reported in 2001 and 2000.
- **The 2002 Medi-Cal managed care average for *Adolescent Well-Care Visits* remained below the NCQA 2001 national Medicaid average.** None of the Medi-Cal managed care plans reported rates above the HPL of 44.4 percent. Three Medi-Cal managed care plans had quality improvement programs in 2001 affecting adolescent well care. The Medi-Cal managed care plan with the highest rate (43.3 percent) in 2002 provided gift certificates to members who received a well-care visit.

[3] The five County Organized Health Systems did not report *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* measure, and instead reported *Eye Exams for People with Diabetes*.

**Figure 3-1—2002 Medi-Cal Managed Care Plans:
Overall Average Rate Comparison for Pediatric Care**



Interpretation

These results suggest that quality improvement efforts by DHS and the Medi-Cal managed care plans may have positively affected the HEDIS rates for the Pediatric Care dimension.

The rate for *Adolescent Well-Care Visits* has been particularly difficult to improve for the Medi-Cal managed care population and nationally. Quality improvement efforts by the Medi-Cal managed care plans have generally focused on the other Pediatric Care measures and less on adolescent well-care. Successful interventions for improving Pediatric Care rates appear to have focused on providing member incentives combined with efforts to improve encounter data submission from providers. It appears that the *Adolescent Well-Care Visits* measure can similarly benefit from focused quality improvement efforts by the Medi-Cal managed care plans. For example, CalOptima improved its rate from 22.7 percent in 1999 to 43.3 percent in 2002 by using several quality improvement interventions. These interventions included an adolescent member incentive program (a gift certificate was given to the member with documentation of a well-care visit), a teen newsletter, provider resources and a provider recognition program for those showing outstanding performance with adolescent members.

Childhood Immunization Status (Combination 1)

Over the last 50 years childhood immunizations have led to dramatic declines in many life-threatening diseases such as polio, tetanus, whooping cough, mumps, measles, and meningitis. However, approximately 300 children still die every year in the United States from these preventable diseases and many more suffer from blindness, hearing loss, diminished motor functioning, liver damage, and coma because they have not been immunized. The federal Centers for Disease Control and Prevention (CDC) recommends immunizing children for ten preventable diseases. While individual immunization rates are high, up to 20 percent of children in the United States are not fully immunized. As a result, there were more than 7,000 cases of whooping cough and more than 1,000 cases of invasive Haemophilus influenzae (HIB) in the United States in 1998.[4]

A recent study in *Pediatrics* notes that "immunization rates are valid and reliable markers of quality pediatric care."[5] The HEDIS *Childhood Immunization Status* measure is based on standards set forth by the Advisory Committee on Immunization Practices (ACIP) and the immunization schedule recommended by CDC.

Results

The 2002 Medi-Cal managed care average of 62.2 percent was exceeded by 50.0 percent (15 of 30) of the health plans. Twenty-three health plans (76.7 percent) had *Combination 1* rates above the NCQA 2001 national Medicaid average of 56.0 percent. Five health plans (16.7 percent) were above the HPL of 69.3 percent, while one health plan reported a rate below the MPL of 41.8 percent.

When extrapolated to the entire eligible population of 80,160 children, the 2002 Medi-Cal managed care average of 62.2 percent implies 49,860 children received the recommended immunizations. If every Medi-Cal managed care plan had rates above the HPL in 2002, 5,691 additional children would have received their recommended immunizations.

[4] National Committee for Quality Assurance. *The State of Managed Care Quality*. Washington, DC: National Committee for Quality Assurance; 2001.

[5] Alessandrini EA, Shaw KN, Bilker WB, Schwarz DF, Bell LM. Effects of Medicaid managed care on quality: Childhood immunizations. *Pediatrics*. 2001;6.

Figure 3-2—2002 Medi-Cal Managed Care Plans: Ranking for *Childhood Immunization Status (Combination 1)*

HEDIS Specification

This measure calculates the number of children who turned two during the reporting year and received all the required immunizations. *Combination 1* is composed of four DTP or DTaP, three OPV or IPV, one MMR, three HIB, and three hepatitis B (HBV) immunizations. In 2000 and 2001, only two doses of HIB were required. HEDIS 2002 required three doses of HIB for the combined rate. Consequently, actual improvement in the combined rate may not appear as substantial for HEDIS 2002.

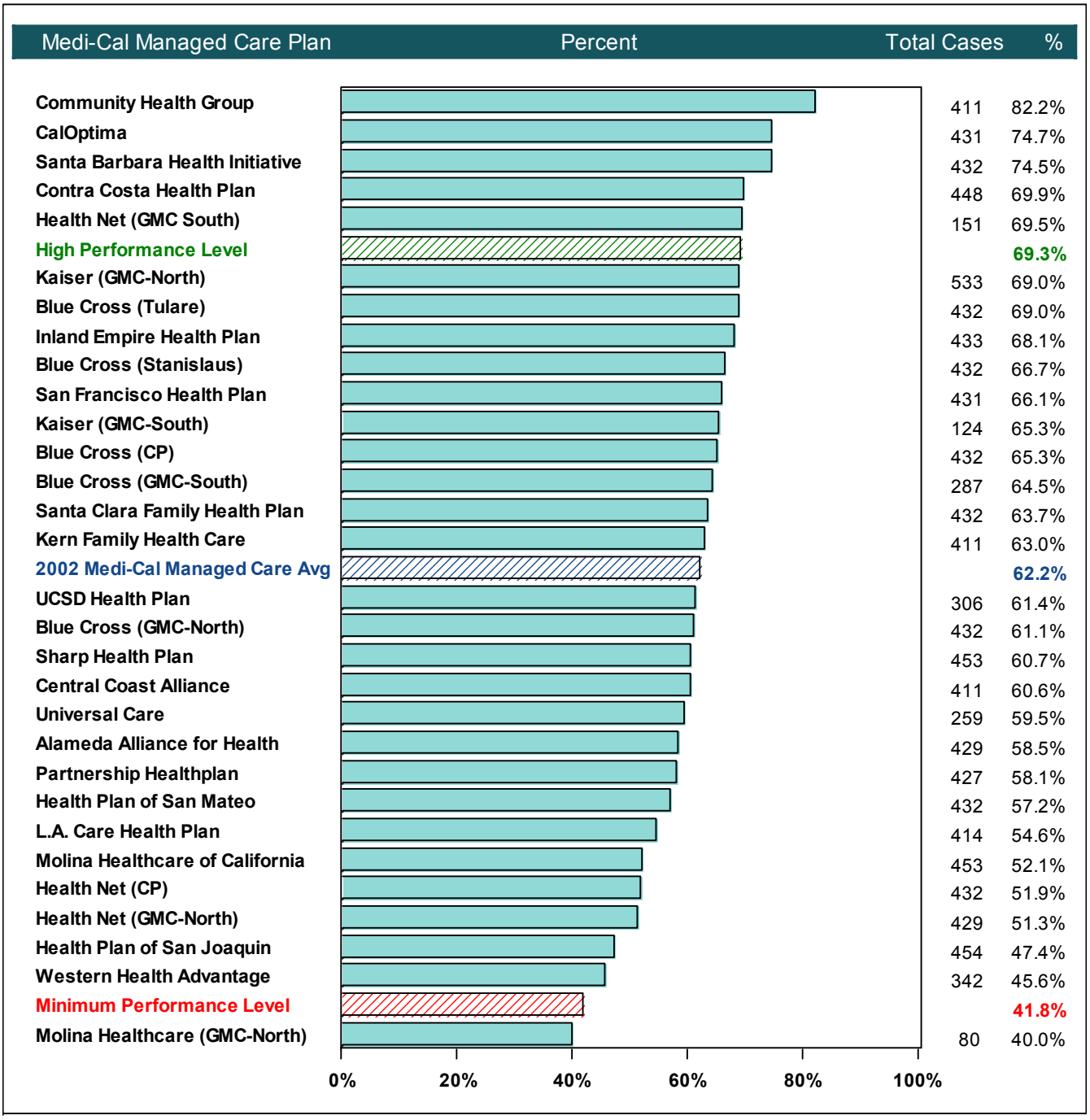
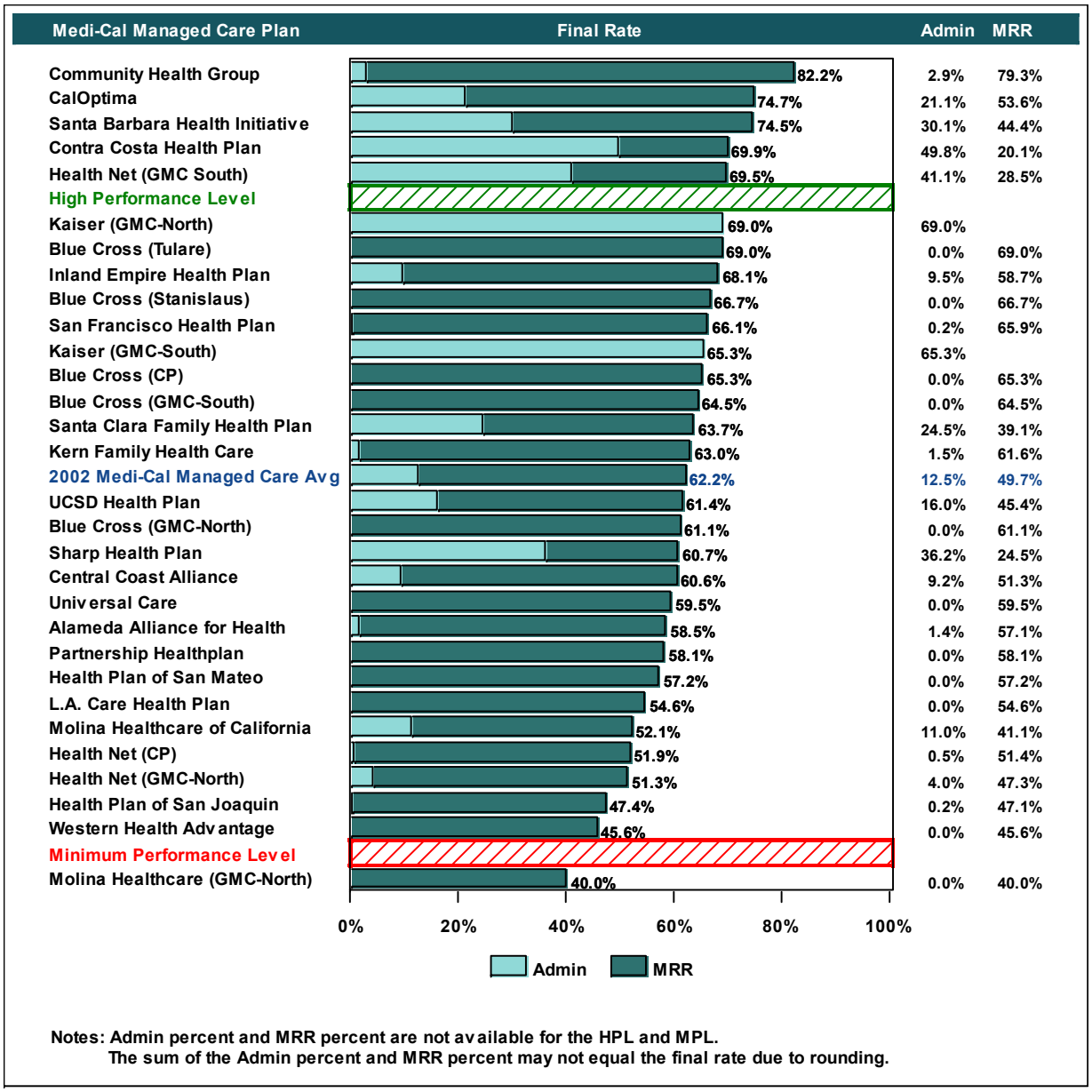


Figure 3-3—2002 Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Childhood Immunization Status (Combination 1)*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

All of the Medi-Cal managed care plans were able to report a rate for this measure; only Kaiser (GMC-North and South) reported this measure using the administrative method.

The 2002 Medi-Cal managed care average of 62.2 percent was derived primarily from medical record review (i.e., the hybrid method). Four Medi-Cal managed care plans were able to use their administrative data to determine the immunization status for more than half of their members. The other health plans did not have complete administrative data and had to rely heavily on medical record review.

These findings indicate the administrative data were mostly incomplete for this HEDIS measure; medical record review, in conjunction with an administrative data search, typically yielded higher HEDIS rates.

Figure 3-4—2002 Medi-Cal Managed Care Plans: 1999-2002 Trends for *Childhood Immunization Status (Combination 1)*

Medi-Cal Managed Care Plan	1999 (%)	2000 (%)	2001 (%)	2002 (%)
Community Health Group	NA	54.0	60.1	82.2
CalOptima	52.6	57.9	62.0	74.7
Santa Barbara Health Initiative	68.8	75.1	73.6	74.5
Contra Costa Health Plan	58.9	62.3	70.3	69.9
Health Net (GMC-South)	NA	NA	51.7	69.5
Blue Cross (Tulare)	NA	NA	54.4	69.0
Kaiser (GMC-North)	NR	58.9	70.3	69.0
Inland Empire Health Plan	55.7	51.9	54.2	68.1
Blue Cross (Stanislaus)	55.6	57.4	61.1	66.7
San Francisco Health Plan	50.8	55.6	57.4	66.1
Blue Cross (CP)	56.4	65.4	63.5	65.3
Kaiser (GMC-South)	NA	66.7	63.7	65.3
Blue Cross (GMC-South)	NA	NA	45.0	64.5
Santa Clara Family Health Plan	46.7	52.1	61.0	63.7
Kern Family Health Care	55.9	54.9	60.6	63.0
Medi-Cal Managed Care Average	50.0	53.8	57.0	62.2
UCSD Health Plan	NA	NA	34.2	61.4
Blue Cross (GMC-North)	58.5	62.2	61.8	61.1
Sharp Health Plan	NA	27.6	45.8	60.7
Central Coast Alliance	38.7	56.5	64.0	60.6
Universal Care	NA	47.9	52.7	59.5
Alameda Alliance for Health	45.7	57.2	55.6	58.5
Partnership Healthplan	59.8	49.5	58.8	58.1
Health Plan of San Mateo	51.9	61.7	60.1	57.2
L.A. Care Health Plan	42.2	46.4	54.8	54.6
Molina Healthcare of California	39.9	39.7	53.6	52.1
Health Net (CP)	44.2	53.6	47.3	51.9
Health Net (GMC-North)	38.5	63.3	56.3	51.3
Health Plan of San Joaquin	45.8	41.0	50.8	47.4
Western Health Advantage	35.8	39.8	43.9	45.6
Molina Healthcare (GMC-North)	NA	NA	NA	40.0

Trends

Between 2001 and 2002, 11 (36.7 percent) Medi-Cal managed care plans reported rate increases of more than five percentage points.

Community Health Group increased its rate by 22.1 percentage points (to 82.2 percent) and reported the highest rate. Community Health Group's quality improvement effort for childhood immunizations included providing incentives for providers to improve encounter data submission and educating providers on HEDIS reporting requirements.

UCSD Health Plan, at 34.2 percent in 2001, had an increase of 27.2 percentage points (to 61.4 percent) in its HEDIS 2002 rate. For 2002, UCSD Health Plan obtained additional immunization data from the county registry.

Only one health plan had a decline of more than five percentage points in its *Combination 1* rate. This was the second year in a row that Health Net (GMC-North) showed a significant decline. Health Net (GMC-North) attributed this decline to continuing organizational change, including using a new vendor to collect and report HEDIS rates, as noted by this plan in 2001.

Quality Improvement Efforts

A summary of the strategies Medi-Cal managed care plans used to improve rates over the last two years is presented below:

- Welcome calls were conducted for every household and subscribers were assisted, when needed, with getting appointments for their children to see a primary care practitioner.
- Postcard reminders were sent to parents of children at 12 months and 18 months of age.
- Gift certificates were issued to parents for children who received all their immunizations.
- Staff resources were increased for collecting and reporting HEDIS data.
- Medical records pursuit was intensified and immunization registry data was obtained.
- Provider awareness and education about recommended childhood immunizations and the importance of HEDIS reporting was increased. Every two months, providers were sent lists of those children needing immunizations.
- Financial incentives were given to providers to improve encounter data submission.

Please reference Appendix D for a detailed listing of *Childhood Immunization Status* quality improvement efforts by individual Medi-Cal managed care plan.

Childhood Immunization Status (Combination 2)

Results

The Medi-Cal managed care average for *Combination 2* has continued to improve significantly since 2000. This improvement can be directly attributed to the increase in the varicella-zoster virus (VZV) immunization rate. This positive trend since 2000 in the Medi-Cal managed care program has shown that even relatively new immunizations can quickly become widely used and accepted.

The 2002 Medi-Cal managed care average of 59.2 percent was exceeded by 16 (53.3 percent) health plans. Ninety percent (27 out of 30) of the Medi-Cal managed care plans reported rates above the NCQA 2001 national Medicaid average of 46.7 percent. Two-thirds (20 out of 30) of the health plans reported rates above the HPL of 55.9 percent for 2002. All of the health plans were above the MPL of 27.6 percent.

Figure 3-5—2002 Medi-Cal Managed Care Plans: Ranking for *Childhood Immunization Status (Combination 2)*

HEDIS Specification

This measure calculates the number of children who turned two during the reporting year and received all the required immunizations. *Combination 2* is composed of four DTP or DTaP, three OPV or IPV, one MMR, three HIB, three hepatitis B (HBV) immunizations and one varicella-zoster (VZV), or chicken pox vaccine.

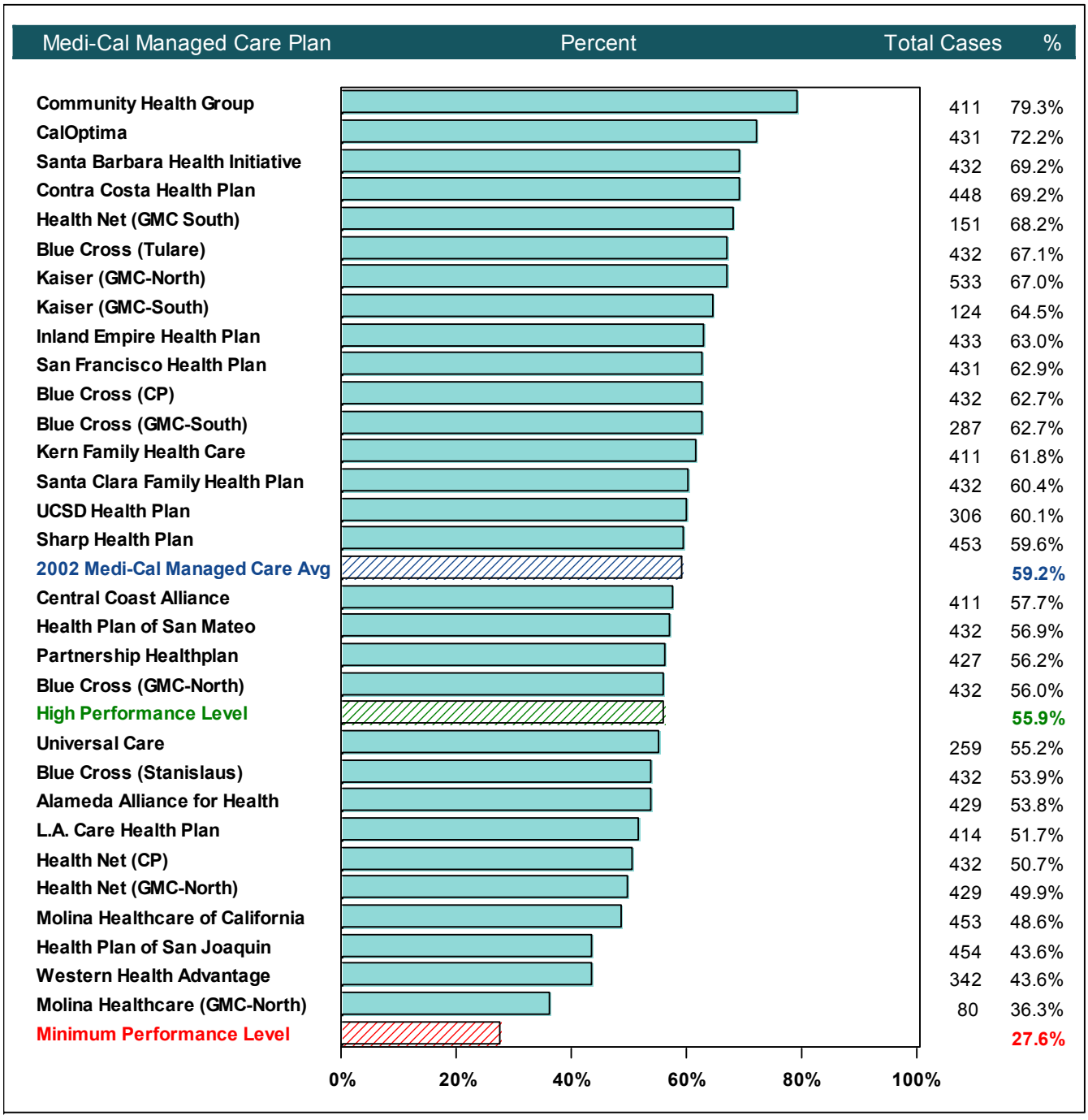
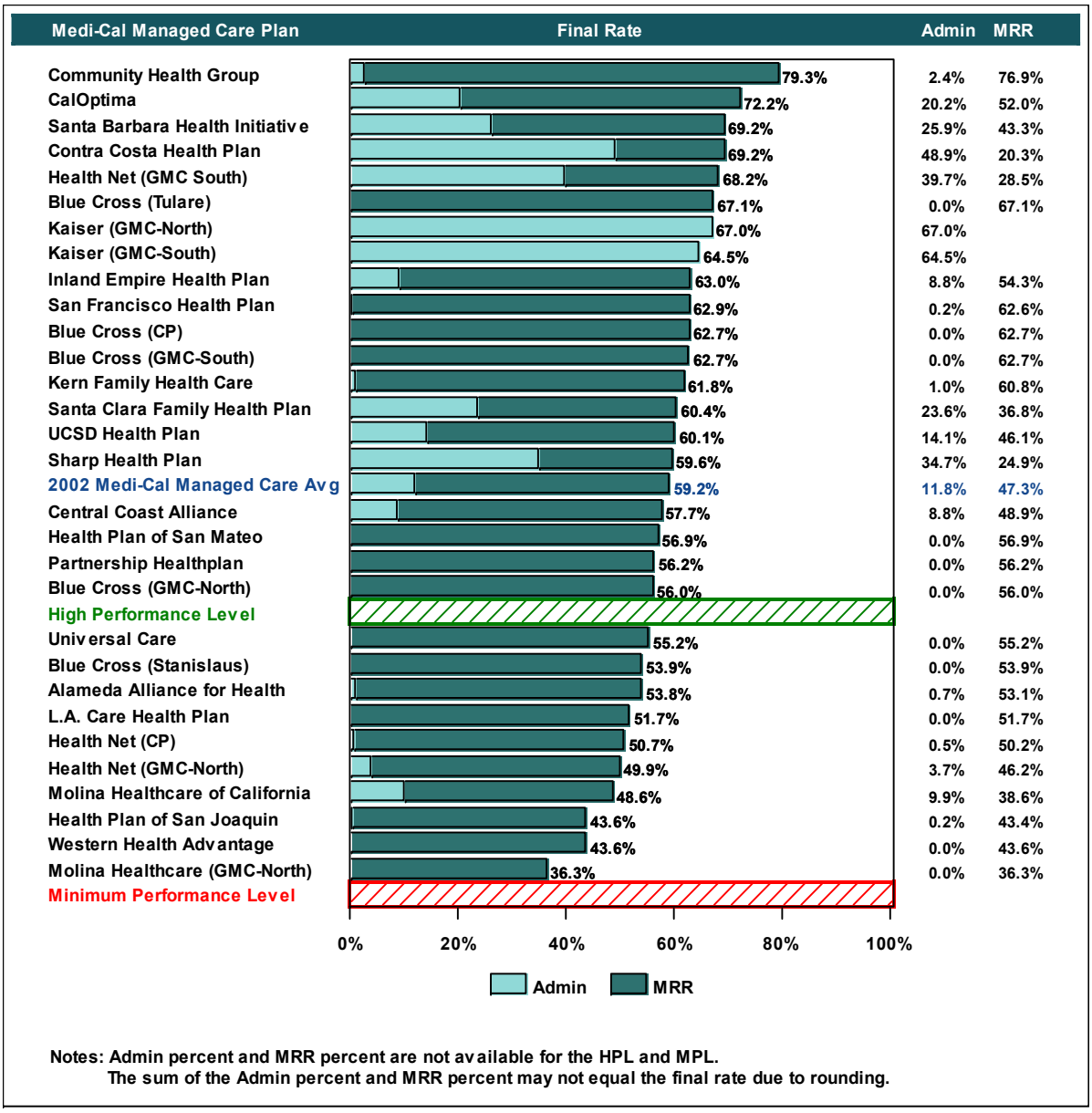


Figure 3-6—2002 Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Childhood Immunization Status (Combination 2)*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

All of the Medi-Cal managed care plans were able to report a rate for this measure; only Kaiser (GMC-North and South) reported this measure using the administrative method.

The 2002 Medi-Cal managed care average of 59.2 percent was derived primarily from medical record review (i.e., the hybrid method). Five Medi-Cal managed care plans were able to use their administrative data to determine the immunization status for more than half of their members. The other health plans did not have complete administrative data and had to rely heavily on medical record review. Overall, the 2002 Medi-Cal managed care average improved by 47.3 percentage points using medical record review. These findings indicate the administrative data were mostly incomplete for this HEDIS measure; medical record review, in conjunction with an administrative data search, typically yielded higher HEDIS rates.

Figure 3-7—2002 Medi-Cal Managed Care Plans: 2000-2002 Trends for *Childhood Immunization Status (Combination 2)*

Medi-Cal Managed Care Plan	2000 (%)	2001 (%)	2002 (%)
Community Health Group	49.6	57.2	79.3
CalOptima	52.3	60.4	72.2
Contra Costa Health Plan	51.8	65.5	69.2
Santa Barbara Health Initiative	63.3	65.4	69.2
Health Net (GMC-South)	NA	46.6	68.2
Blue Cross (Tulare)	NA	49.1	67.1
Kaiser (GMC-North)	52.4	66.8	67.0
Kaiser (GMC-South)	66.0	59.8	64.5
Inland Empire Health Plan	39.8	47.9	63.0
San Francisco Health Plan	47.2	51.4	62.9
Blue Cross (CP)	52.7	57.2	62.7
Blue Cross (GMC-South)	NA	41.7	62.7
Kern Family Health Care	48.4	57.2	61.8
Santa Clara Family Health Plan	42.4	53.6	60.4
UCSD Health Plan	NA	32.0	60.1
Sharp Health Plan	24.7	40.7	59.6
Medi-Cal Managed Care Average	44.3	51.5	59.2
Central Coast Alliance	43.8	58.6	57.7
Health Plan of San Mateo	53.4	55.7	56.9
Partnership Healthplan	44.2	54.9	56.2
Blue Cross (GMC-North)	52.2	55.8	56.0
Universal Care	36.2	48.5	55.2
Blue Cross (Stanislaus)	23.8	44.9	53.9
Alameda Alliance for Health	46.5	48.6	53.8
L.A. Care Health Plan	38.7	49.0	51.7
Health Net (CP)	48.5	43.9	50.7
Health Net (GMC-North)	55.9	51.9	49.9
Molina Healthcare of California	31.1	45.7	48.6
Health Plan of San Joaquin	29.9	43.0	43.6
Western Health Advantage	32.4	40.0	43.6
Molina Healthcare (GMC-North)	NA	NA	36.3

Note: *Childhood Immunization Status (Combination 2)* specifications were revised in 2000. Therefore, 1999 data is not available for this measure.

Trends

For the *Combination 2* rate, the overall Medi-Cal managed care average has improved from 44.3 percent in 2000 to 59.2 percent in 2002, or 14.9 percentage points. For HEDIS 2002, the Medi-Cal managed care average reached 56.9 percent.

With the increase in the use of VZV, *Combination 2* has now reached an immunization rate slightly below the *Combination 1* rate. Since *Combination 2* consists of *Combination 1* plus one VZV immunization, the *Combination 2* rate can never be higher than the *Combination 1* rate. The fact that *Combination 2* rate for 2002 was just three percentage points less than the *Combination 1* rate reinforces the increased use of VZV.

Quality Improvement Efforts

Combination 2 is the second numerator in the *Childhood Immunization Status* measure. Medi-Cal managed care plans used the same quality improvement efforts for both *Combination 1* and *Combination 2*.

Well-Child Visits in the First 15 Months of Life (Six or More Visits)

The American Academy of Pediatrics (AAP) recommends six well-child visits in the first year of life.[6] These well-child visits provide opportunities for the primary care providers to detect physical, developmental, behavioral and emotional problems and provide early interventions and treatment and appropriate referrals to specialists. The AAP also recommends that clinicians use these visits to offer counseling and guidance to the parents.[7]

The American Medical Association, the federal Bright Future program, and the AAP all recommend comprehensive periodic well-child visits for children.[7] These periodic checkups provide opportunities for addressing the physical, emotional and social aspects of their health.

Results

For 2002, 58.6 percent (17 out of 29) of the health plans were above the NCQA 2001 national Medicaid average of 33.8 percent. Three health plans reported rates above the HPL of 57.9 percent, while one health plan reported a rate below the MPL of 18.1 percent.

When extrapolated to the entire eligible population of 23,721 children, the 2002 Medi-Cal managed care average of 41.3 percent implies 9,797 children had six well-child visits by 15 months of age. If every Medi-Cal managed care plan were above the HPL in 2002, then 13,734 children (i.e., 3,937 additional children) would have had the recommended six well-child visits by 15 months of age.

[6] American Academy of Pediatrics. Recommendations for Preventive Pediatric Health Care (RE9939). *American Academy of Pediatrics Policy Statement*. March 2000; 105: 3-645.

[7] American Medical Association. *Guidelines for Adolescent Preventive Services (GAPS*). American Medical Association, Department of Adolescent Health; 1997:1.

Figure 3-8—2002 Medi-Cal Managed Care Plans: Ranking for *Well-Child Visits in the First 15 Months of Life*

HEDIS Specification

The percentage of children who turned 15 months old during the measurement year and who received six or more visits with a primary care practitioner during their first 15 months of life.

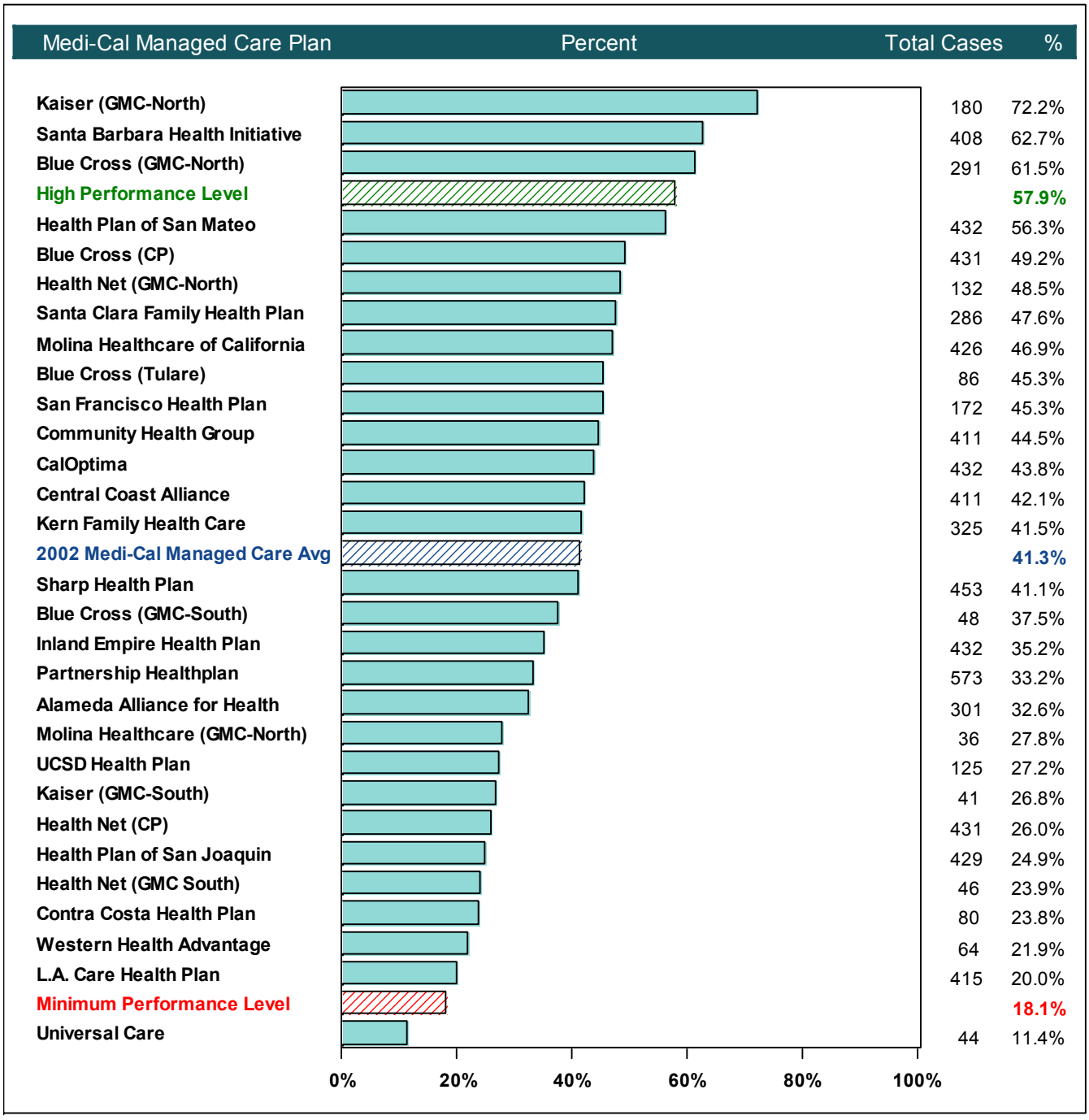
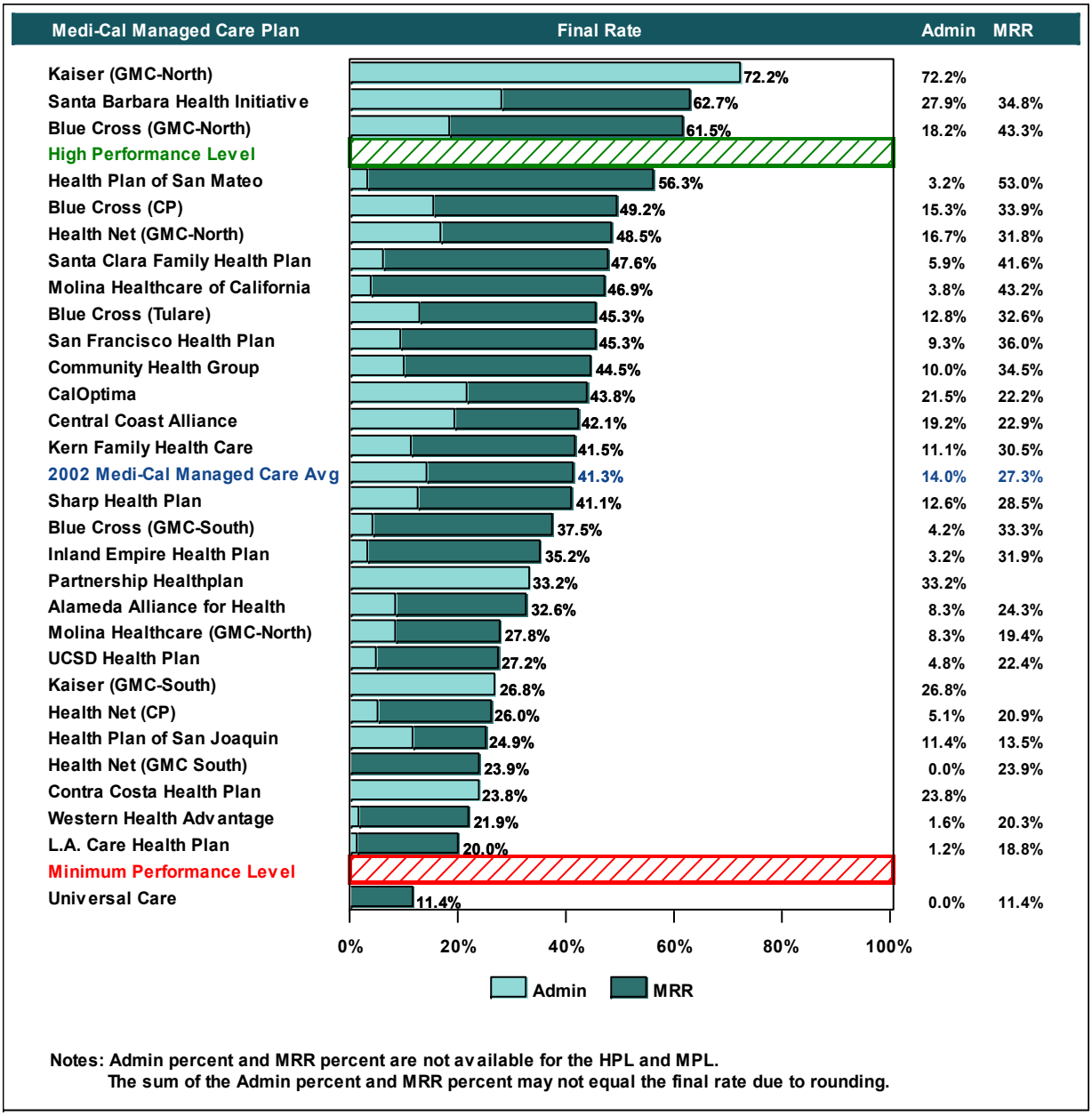


Figure 3-9—2002 Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Well-Child Visits in the First 15 Months of Life*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

All of the health plans were able to report a rate for this measure. The 2002 Medi-Cal managed care average of 41.3 percent was derived primarily from medical record review (i.e., 27.3 percent from the medical record review and 14.0 percent from administrative data).

Four health plans used the administrative method to report this measure. The other health plans did not have complete administrative data and had to rely heavily on medical record review.

These findings indicate the administrative data were mostly incomplete for this HEDIS measure; medical record review, in conjunction with an administrative data search, typically yielded higher HEDIS rates.

Figure 3-10—2002 Medi-Cal Managed Care Plans: 1999-2002 Trends for *Well-Child Visits in the First 15 Months of Life*

Medi-Cal Managed Care Plan	1999 (%)	2000 (%)	2001 (%)	2002 (%)
Kaiser (GMC-North)	NR	63.9	66.7	72.2
Santa Barbara Health Initiative	42.9	58.1	62.3	62.7
Blue Cross (GMC-North)	6.5	53.6	52.4	61.5
Health Plan of San Mateo	40	44.2	47.7	56.3
Blue Cross (CP)	6.7	40.5	45.8	49.2
Health Net (GMC-North)	30	43.4	41.4	48.5
Santa Clara Family Health Plan	38.2	27.1	27.0	47.6
Molina Healthcare of California	1.5	8.2	9.3	46.9
Blue Cross (Tulare)	NA	NA	10.4	45.3
San Francisco Health Plan	48.7	67.4	64.2	45.3
Community Health Group	NA	0.0	25.2	44.5
CalOptima	23.8	36.8	NR	43.8
Central Coast Alliance	19.9	49.5	56.7	42.1
Kern Family Health Care	30.6	38.4	38.0	41.5
Medi-Cal Managed Care Average	26	32.9	37.6	41.3
Sharp Health Plan	NA	NR	NR	41.1
Blue Cross (GMC-South)	NA	NA	NA	37.5
Inland Empire Health Plan	16.3	24.3	24.1	35.2
Partnership Healthplan	52	21.6	32.6	33.2
Alameda Alliance for Health	26.1	31.1	33.0	32.6
Molina Healthcare (GMC-North)	NA	NA	NA	27.8
UCSD Health Plan	NA	NA	NR	27.2
Kaiser (GMC-South)	NA	NA	NA	26.8
Health Net (CP)	16.2	27.2	25.7	26.0
Health Plan of San Joaquin	NR	33.5	35.2	24.9
Health Net (GMC-South)	NA	NA	NA	23.9
Contra Costa Health Plan	NA	21.4	34.8	23.8
Western Health Advantage	12.9	40.0	36.5	21.9
L.A. Care Health Plan	NR	8.2	13.7	20.0
Universal Care	NA	NA	NA	11.4
Blue Cross (Stanislaus)	NA	23.1	45.2	NA

Trends

The rates improved by more than five percentage points for 33.3 percent (10 out of 30) of the health plans. Three of these 10 health plans improved more than 20.0 percentage points and another two improved by more than 10.0 percentage points.

Five health plans had significant declines between 2001 and 2002. Contra Costa Health Plan attributed its decline to the use of the administrative method. The hybrid method, which uses administrative data and medical record review, tended to result in higher rates.

In 2001, Western Health Advantage changed its payment structure for providers and began paying providers on a fee-for-service basis for well-child visits. This incentive was expected to increase the HEDIS 2001 and HEDIS 2002 rates. On further investigation, Western Health Advantage discovered providers were completing more "partial" well-care visits. In other words, as part of the standardized methodology, HEDIS requires the well-care visits to consist of a history, physical examination, and health education. The "partial" well-care visits typically only had two of the three required components of the well-care visit. Western Health Advantage indicated that it intends to conduct provider education and training to improve this HEDIS rate.

Central Coast Alliance began operating in a second county (Monterey) in October 1999. This new county doubled its eligible members for HEDIS 2001, which contributed to the decline in this health plan's rates for 2001 and 2002.

The other two health plans that had significant declines in HEDIS rates were Health Plan of San Joaquin and San Francisco Health Plan.

Quality Improvement Efforts

For the second consecutive year, Community Health Group had a substantial increase in its rate. Blue Cross (GMC-North), Blue Cross (Tulare), and Santa Clara Family Health Plan also reported significant increases. The strategies these Medi-Cal managed care plans used in 2000 and 2001 to improve rates are presented below:

- Increased provider awareness and education about recommended services and the importance of HEDIS reporting;
- Improved encounter data submission by giving incentives to providers;
- Sent mailings to parents to remind them of the need for well-child visits; and
- Reminded mothers of newborns of the importance of well-child visits for infants and the need to enroll the child in Medi-Cal.

Please reference Appendix D for a detailed listing of *Well-Child Visits in the First 15 Months of Life* quality improvement efforts by individual Medi-Cal managed care plan.

Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life

The AAP recommends annual well-child visits for children three to six years of age.[6] These check-up visits during the preschool and early school years allow clinicians to detect vision, speech, and language problems at the earliest opportunity. Early intervention in these areas can improve the child's communication skills and reduce language and learning problems.

Results

The NCQA 2001 national Medicaid average of 50.5 percent was exceeded by 88.0 percent (22 of the 25) of the reporting Medi-Cal managed care plans. One Medi-Cal managed care plan had a rate higher than the HPL of 68.2 percent. None were below the MPL of 38.9 percent. The 2002 Medi-Cal managed care average of 59.6 percent increased 3.2 percentage points over 2001.

When extrapolated to the entire eligible population of 314,496 children, the Medi-Cal managed care average of 59.6 percent implies 187,444 children between three and six years of age had a well-child visit in 2002. Furthermore, if every Medi-Cal managed care plan were above the HPL in 2002, then a minimum of 27,042 additional children would have had a well-child visit.

Figure 3-11—2002 Medi-Cal Managed Care Plans: Ranking for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life*

HEDIS Specification

This measure determines the percentage of members who were between three and six years of age as of December 31, 2001, and who had at least one well-child visit with a primary care practitioner during 2001.

The COHS managed care plans did not report this measure. Due to their different population characteristics, they reported the rate for *Eye Exams for People with Diabetes* instead.

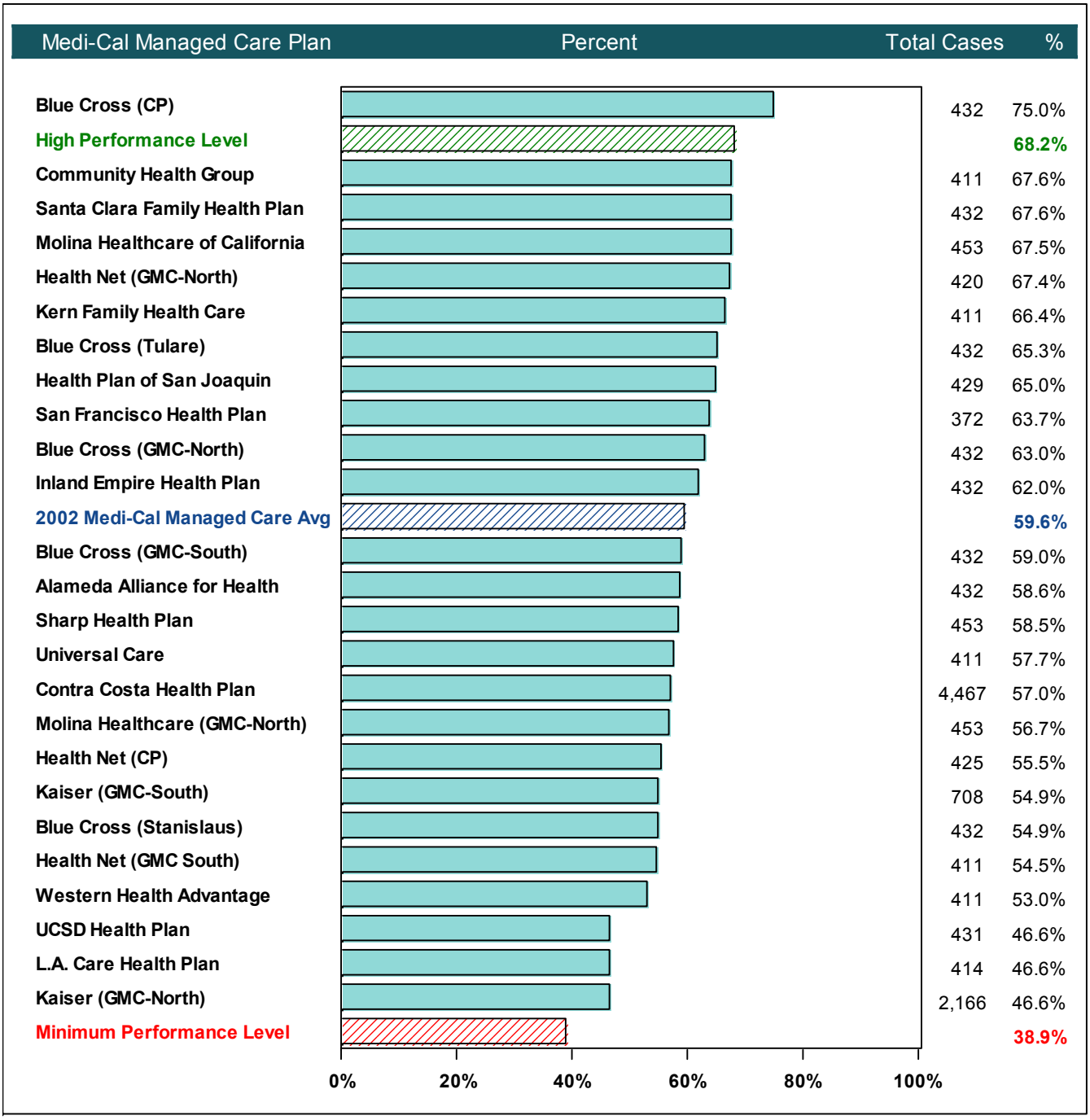
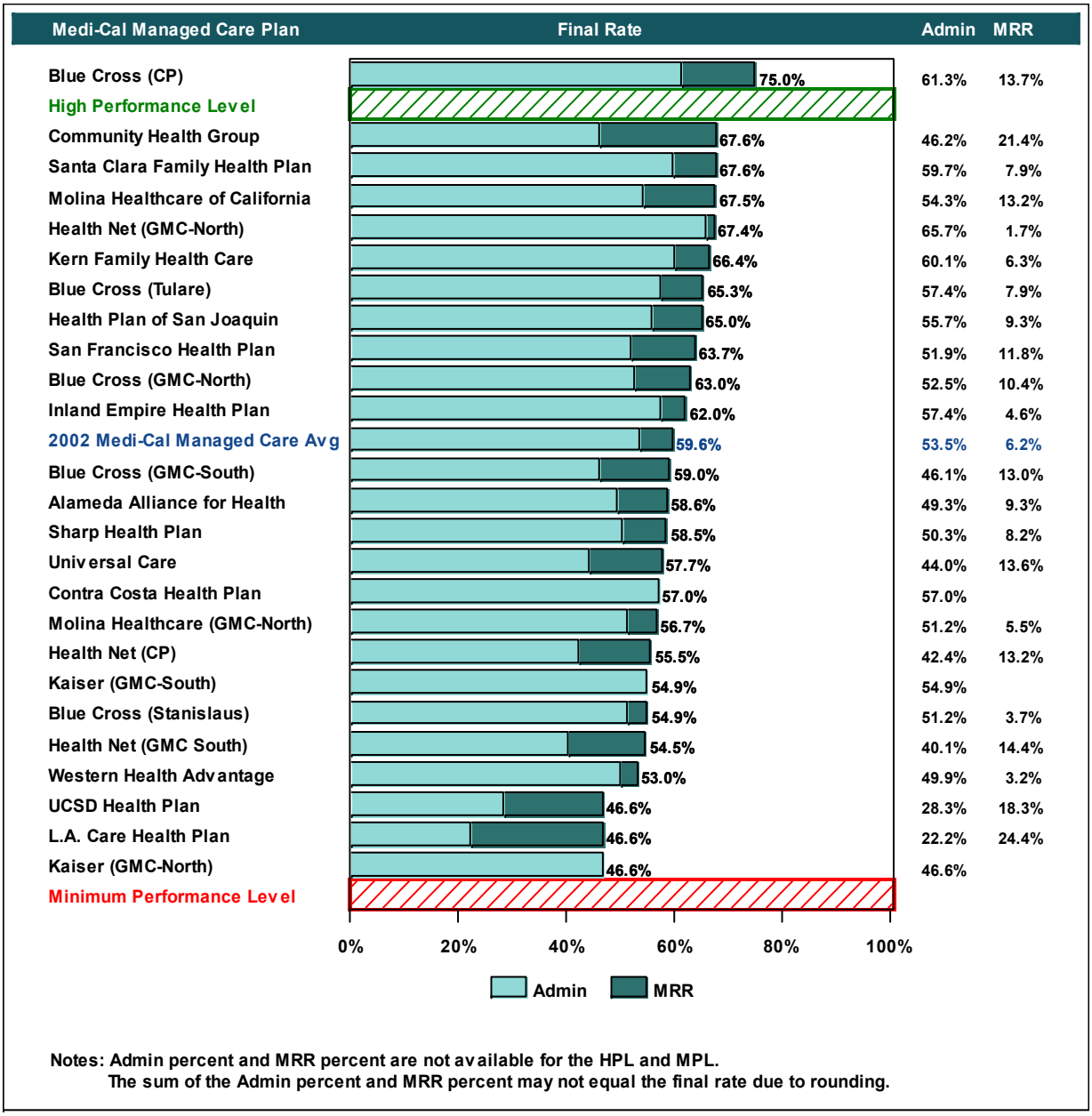


Figure 3-12—2002 Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

Three of the 25 Medi-Cal managed care plans reporting rates elected to use the administrative methodology. The Medi-Cal managed care average for this measure was 59.6 percent. Medical record review contributed 6.2 percentage points to the Medi-Cal managed care overall average rate. These findings indicate the administrative data are largely complete for this HEDIS measure.

Figure 3-13—2002 Medi-Cal Managed Care Plans: 1999-2002 Trends for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life*

Medi-Cal Managed Care Plan	1999 (%)	2000 (%)	2001 (%)	2002 (%)
Blue Cross (CP)	59.8	65.5	62.5	75.0
Community Health Group	NA	58.6	66.9	67.6
Santa Clara Family Health Plan	55.5	60.2	64.1	67.6
Molina Healthcare of California	48.4	57.7	60.5	67.5
Health Net (GMC-North)	59.4	60.2	59.5	67.4
Kern Family Health Care	61.0	65.3	60.0	66.4
Blue Cross (Tulare)	NA	NA	57.4	65.3
Health Plan of San Joaquin	52.4	62.7	57.4	65.0
San Francisco Health Plan	63.8	57.4	68.6	63.7
Blue Cross (GMC-North)	55.7	56.6	56.3	63.0
Inland Empire Health Plan	45.5	52.0	61.1	62.0
Medi-Cal Managed Care Average	51.7	56.7	56.4	59.6
Blue Cross (GMC-South)	NA	49.1	49.9	59.0
Alameda Alliance for Health	48.8	58.3	57.6	58.6
Sharp Health Plan	NA	55.1	79.0	58.5
Universal Care	NA	43.1	51.6	57.7
Contra Costa Health Plan	74.0	74.3	54.5	57.0
Molina Healthcare (GMC-North)	NA	NA	NA	56.7
Health Net (CP)	42.4	49.2	50.2	55.5
Blue Cross (Stanislaus)	47.7	47.2	54.1	54.9
Kaiser (GMC-South)	NA	78.9	48.6	54.9
Health Net (GMC-South)	NA	NA	43.5	54.5
Western Health Advantage	34.3	55.8	52.5	53.0
Kaiser (GMC-North)	NR	48.5	47.1	46.6
L.A. Care Health Plan	28.6	40.5	47.5	46.6
UCSD Health Plan	NA	NA	45.9	46.6

Trends

Twelve health plans (48.0 percent) improved their rates by more than 5.0 percentage points, and two of those health plans achieved an increase of more than 10.0 percentage points.

Only Sharp Health Plan had a significant decline of over five percentage points in its rate between 2001 and 2002.

Quality Improvement Efforts

Blue Cross (with the exception of Stanislaus County) improved between 6.7 and 12.5 percentage points over 2001. Universal Care also had a 6.1 percentage point increase. The strategies these Medi-Cal managed care plans used in 2000 and 2001 to improve HEDIS rates are presented below:

- Mailing postcards at regular intervals to parents to remind them of the need for their children to get recommended services; and
- Initiation of provider incentive programs improved encounter data submission from providers.

Please reference Appendix D for a detailed listing of *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* quality improvement efforts by individual Medi-Cal managed care plan.

Adolescent Well-Care Visits

Adolescence is a period of profound change. More changes take place in anatomy, physiology, mental and emotional functioning, and social development during adolescence than in any other life stage, except infancy. Unintentional injuries, homicide, and suicide are the leading causes of adolescent death. Sexually transmitted diseases, substance abuse, pregnancy, and anti-social behavior are important causes of physical, emotional, and social adolescent problems. The attitudes and behaviors molded during adolescence often determine the lifestyle and health habits of adulthood, creating long-term health implications.

The American Medical Association, the federal government's Bright Future program, and the AAP all recommend comprehensive annual checkups for adolescents.[7] These annual checkups provide opportunities for addressing the physical, emotional and social aspects of adolescents' health.

Results

For 2002, 36.7 percent (11 out of 30) of the Medi-Cal managed care plans were above the NCQA 2001 national Medicaid average of 30.2 percent. The rates ranged from a low of 16.1 percent to a high of 43.3 percent, and none of the Medi-Cal managed care plans were above the established HPL of 44.4 percent for 2002.

Three Medi-Cal managed care plans (10.0 percent) were below the MPL of 19.3 percent and five had rates that declined by more than five percentage points.

When extrapolated to the entire eligible population of 482,333 adolescents, the Medi-Cal managed care average of 28.2 percent implies 136,018 adolescents had a well-care visit in 2002. If every Medi-Cal managed care plan were above the HPL in 2002, then a minimum of 78,138 additional members would have had an adolescent well-care visit. Similarly, improving the rates for those Medi-Cal managed care plans that were below the MPL in 2002 implies another 4,152 members would have received an adolescent well-care visit.

Nationally, the rates for *Adolescent Well-Care Visits* have been low for Medicaid and commercial health plan populations.

In recognition of the low HEDIS rates for *Adolescent Well-Care Visits*, DHS will be facilitating a statewide collaborative quality improvement project.

Figure 3-14—2002 Medi-Cal Managed Care Plans: Ranking for *Adolescent Well-Care Visits*

HEDIS Specification

This measure determines the percentage of members who were between 12 and 21 years of age as of December 31, 2001, and who had at least one comprehensive adolescent well-care visit with a primary care practitioner or an obstetrician/gynecologist during 2001.

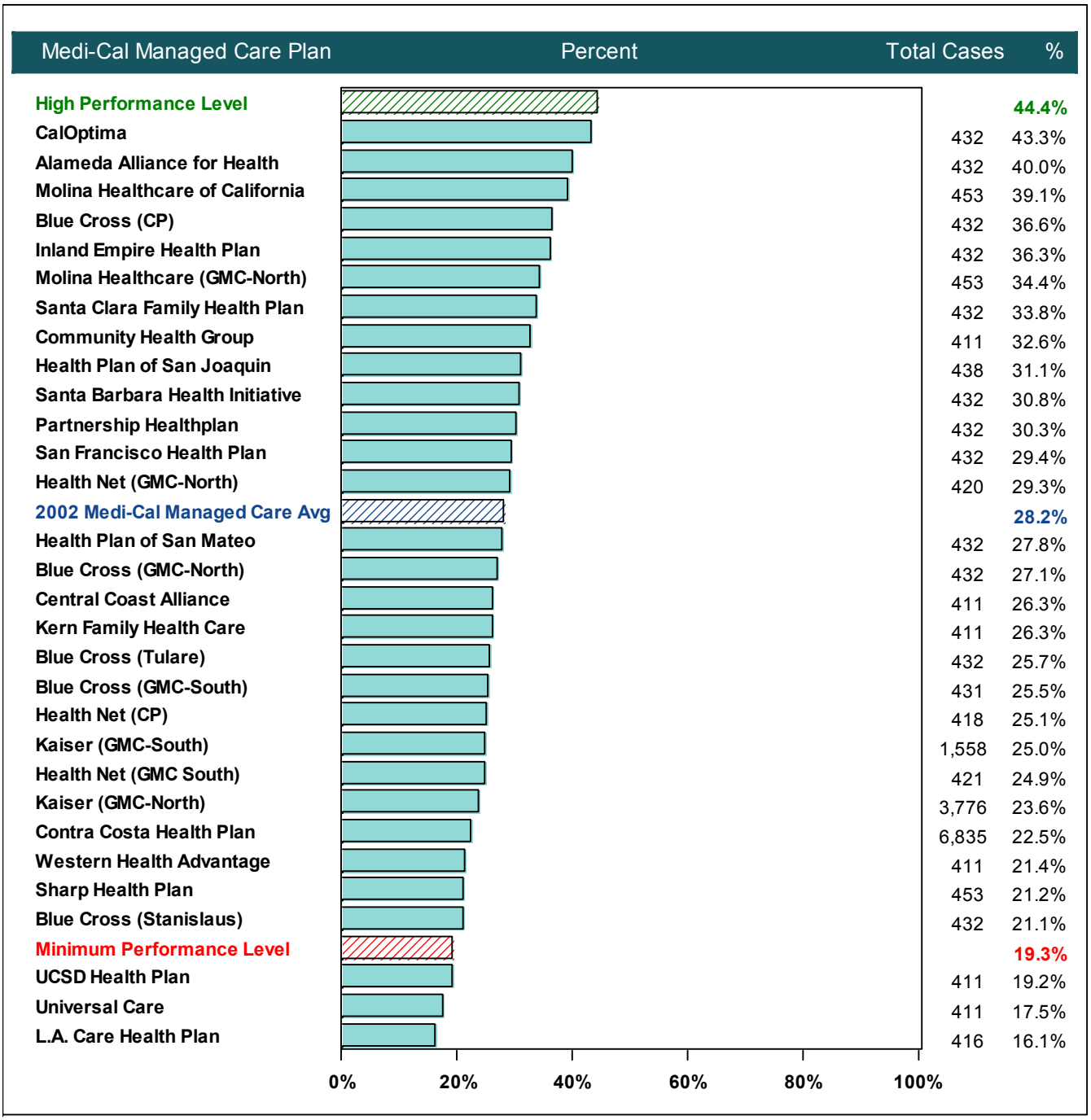
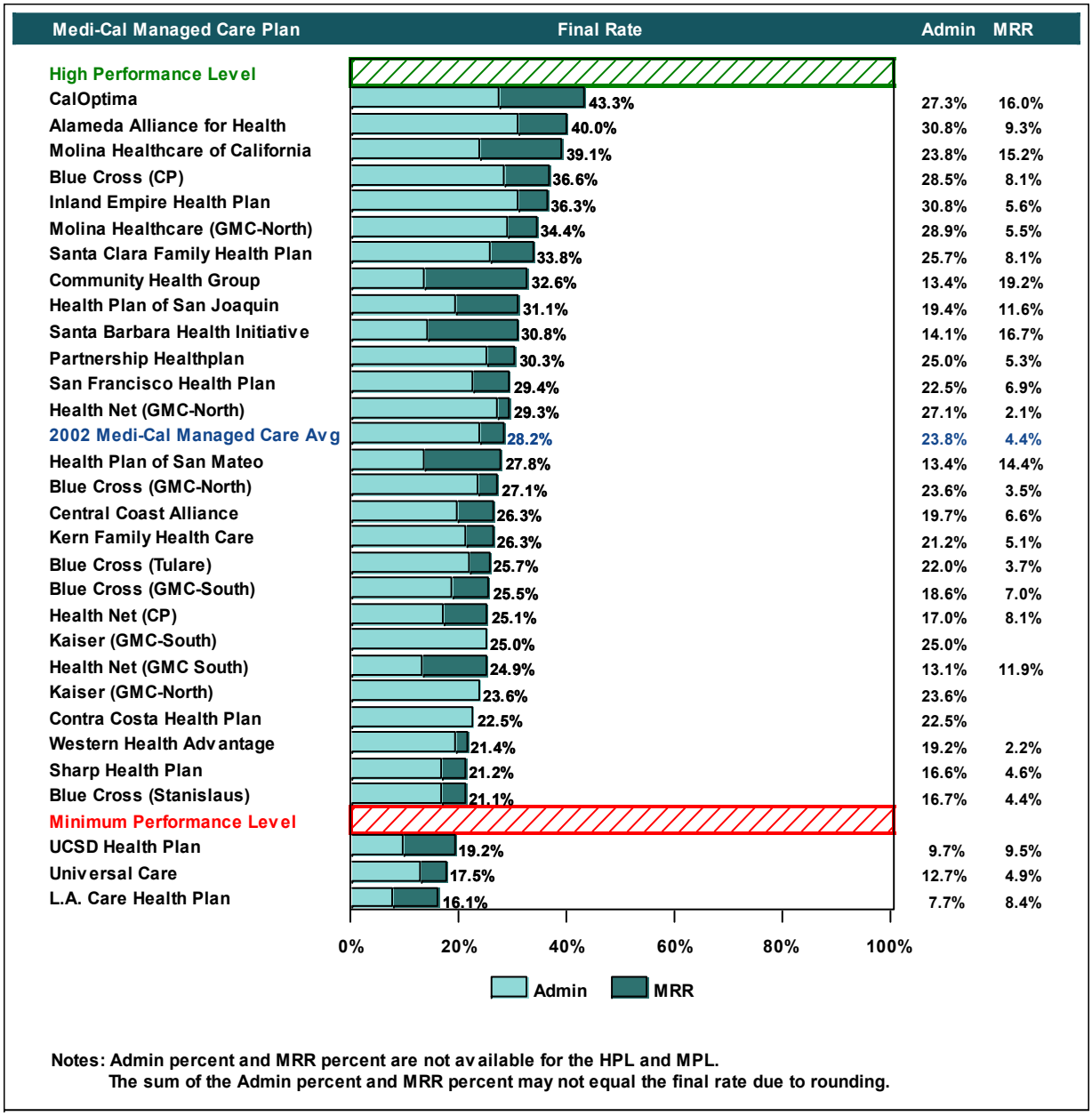


Figure 3-15—2002 Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Adolescent Well-Care Visits*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

Three Medi-Cal managed care plans elected to use the administrative methodology. The Medi-Cal managed care average for this measure was 28.2 percent. Almost the entire Medi-Cal managed care average rate was derived from administrative data. Medical record review added more than 10.0 percentage points to the reported rates for seven health plans. Medical record review contributed 4.4 percentage points to the Medi-Cal managed care overall average rate.

These findings indicate the administrative data in many health plans were largely complete for this HEDIS measure; with the exception of the seven health plans, the medical record review did not appear to substantially improve the overall HEDIS rates.

Figure 3-16—2002 Medi-Cal Managed Care Plans: 1999-2002 Trends for *Adolescent Well-Care Visits*

Medi-Cal Managed Care Plan	1999 (%)	2000 (%)	2001 (%)	2002 (%)
CalOptima	22.7	35.2	40.3	43.3
Alameda Alliance for Health	23.6	34.5	32.9	40.0
Molina Healthcare of California	20.2	31.4	29.4	39.1
Blue Cross (CP)	20.1	23.5	30.1	36.6
Inland Empire Health Plan	23.1	35.9	31.5	36.3
Molina Healthcare (GMC-North)	NA	NA	NA	34.4
Santa Clara Family Health Plan	20	31.5	32.6	33.8
Community Health Group	NA	29.4	29.4	32.6
Health Plan of San Joaquin	12.9	40.3	37.3	31.1
Santa Barbara Health Initiative	28.8	26.4	22.7	30.8
Partnership Healthplan	29.9	27.3	35.6	30.3
San Francisco Health Plan	29.7	30.4	35.6	29.4
Health Net (GMC-North)	32.4	40.4	35.9	29.3
Medi-Cal Managed Care Average	21.2	29.9	26.9	28.2
Health Plan of San Mateo	26	27.3	24.5	27.8
Blue Cross (GMC-North)	17.8	26.9	26.3	27.1
Central Coast Alliance	19	33.8	23.6	26.3
Kern Family Health Care	19.2	32.4	27.1	26.3
Blue Cross (Tulare)	NA	NA	21.1	25.7
Blue Cross (GMC-South)	NA	19.3	18.3	25.5
Health Net (CP)	16.9	28.7	25.3	25.1
Kaiser (GMC-South)	NA	50.2	17.9	25.0
Health Net (GMC-South)	NA	NA	24.5	24.9
Kaiser (GMC-North)	NR	24.3	23.5	23.6
Contra Costa Health Plan	21.5	34.2	22.6	22.5
Western Health Advantage	12.7	34.8	25.8	21.4
Sharp Health Plan	NA	24.9	28.0	21.2
Blue Cross (Stanislaus)	17.5	18.3	20.2	21.1
UCSD Health Plan	NA	NA	21.9	19.2
Universal Care	NA	19.7	18.5	17.5
L.A. Care Health Plan	8.2	17.4	16.6	16.1

Trends

The rates for this measure have been particularly difficult to improve on a consistent basis, both nationally and for the Medi-Cal managed care plans. The Medi-Cal managed care average has not shown consistent improvement in the past three years.

Quality Improvement Efforts

The reason the rates for this measure continue to be low has been investigated with the individual Medi-Cal managed care plans.

Most health plans agree motivating adolescents to visit their physicians for well-care visits has been challenging. Nonetheless, two Medi-Cal managed care plans have improved this rate and their quality improvement efforts are provided below:

- CalOptima implemented successful strategies that improved its rate from 22.7 percent in 1999 to 43.3 percent in 2002 (compared with the 2001 NCQA national Medicaid average of 30.2 percent). At CalOptima, an interdepartmental Pediatric Preventive Services team was formed to develop and launch appropriate interventions. These included an adolescent member incentive program (a gift certificate was given to the member with documentation of a well-care visit), a teen newsletter, provider resources, and a provider recognition program for those showing outstanding performance with adolescent members.[8]
- Alameda Alliance for Health began paying providers on a fee-for-service basis in addition to the providers' capitation rate to improve data reporting. The rate for Alameda Alliance for Health improved from 32.9 percent in 2001 to 40.0 percent in 2002.

Please reference Appendix D for a detailed listing of *Adolescent Well-Care Visits* quality improvement efforts by individual Medi-Cal managed care plan.

[8] Daly DM, MSPH; Nguyen HT, et al. Improving the rate of adolescent well care visits: Case study from a Medicaid managed care plan. *Provider Operations*. CalOptima.

Pediatric Care Summary

Since 2000, the Medi-Cal managed care plans have improved the rates for three of the four Pediatric Care measures.

For the 2002 childhood immunizations, 76.7 percent (23 out of 30) of the Medi-Cal managed care plans reported rates above the NCQA 2001 national Medicaid average, and five rates were above the HPL of 69.3 percent. The majority of Medi-Cal managed care plans relied on the hybrid method to report *Childhood Immunization Status* because they did not capture all the immunizations provided to the members in their administrative data.

The 2002 Medi-Cal managed care average of 41.3 percent for *Well-Child Visits in the First 15 Months of Life* was 7.5 percentage points higher than the NCQA 2001 national Medicaid average of 33.8 percent. In 2001, three Medi-Cal managed care plans were above the HPL of 57.9 percent and seven were below the MPL of 18.1 percent. For 2002, three Medi-Cal managed care plans were above the HPL and only one reported a rate below the MPL. The majority of Medi-Cal managed care plans relied on the hybrid method to report *Well-Child Visits in the First 15 Months of Life* because their administrative data in general did not capture all six of the well-child visits provided to the members.

For *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life*, the NCQA 2001 national Medicaid average of 50.5 percent was exceeded by 88.0 percent of the reporting Medi-Cal managed care plans in 2002. One Medi-Cal managed care plan had a higher rate than the HPL of 68.2 percent. None were below the MPL of 38.9 percent**.**

The Medi-Cal managed care average for *Adolescent Well-Care Visits* has not shown any improvement since 2000. While the majority of Medi-Cal managed care plans had quality improvement efforts targeting young children, only three of the Medi-Cal managed care plans had some type of focus on adolescent well-care visits. For two of those three Medi-Cal managed care plans, the focus was on improving submission of encounter data. The Medi-Cal managed care plan that reported the highest rate used member incentives to encourage preventive care visits.

The majority of the Medi-Cal managed care rates for *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* and *Adolescent Well-Care Visits* were derived from administrative data. This suggests the administrative data are largely complete for these two HEDIS measures (i.e., medical record review typically does not significantly improve these HEDIS rates) and may be due to the fact that only one visit is required to count toward the numerators.

Pediatric Care Recommendations

Identify Root Causes for Any Low HEDIS Rate in the Pediatric Care Dimension

- The Medi-Cal managed care plans with low rates on any HEDIS measure should perform internal system-wide analyses to assess root causes and barriers for the low rates. Targeted interventions can then be implemented based on the results of this analysis.

Develop Adolescent Well-Care Delivery System Improvement Strategies

- The development and implementation of innovative adolescent care delivery system strategies by health plans is strongly encouraged. The *Adolescent Well-Care Visits* measure characteristically has low reported rates. Medical record review does not appear to have much impact on increasing the rates for this measure. Eighty-four percent of the members who received a well-care visit were identified using administrative data. It may prove beneficial for health plans to report this measure administratively and redirect the resources to designing better delivery systems for adolescent well care.

Develop Mechanisms for Programmatic Tracking of Newborn Eligibility

- Efforts should be made by the Medi-Cal managed care plans to programmatically track newborn eligibility. For the HEDIS measure *Well-Child Visits in the First 15 Months of Life*, newborns are usually covered under the mothers' identification (ID) for the first two months of life. It is important for Medi-Cal managed care plans to make this link and consider the child enrolled for the first two months. Performing this calculation manually is expensive, time consuming, and may lead to potential errors.

Continue Efforts to Improve Encounter Data Submission

- Health plans should continue to improve and monitor encounter data submission. There should be appropriate follow-up for those providers who do not submit complete encounter data on a timely basis. This will improve the completeness of the encounter data and may decrease the need for medical record review.

Consider the Utilization of All Available Administrative Data Sources

- Medi-Cal managed care plans should utilize all available data sources. This includes administrative data, the Provider Manual (PM) -160 data, and immunization data from each county registry.

Develop a Mechanism for Tracking Missing Records During the Medical Record Pursuit Phase of Data Collection

- Missing medical records should be tracked during medical record pursuit. This facilitates improvements in future data collection processes and allows for targeted quality improvement, if needed (e.g., providers who do not submit medical records can be easily determined).

Target Preventive Services Outreach Efforts to Under-served Segments of the Medi-Cal Population

- Enhanced outreach and culturally appropriate member education programs should be undertaken to improve the under-utilization of preventive services, especially among adolescents. Incentive programs and effective member reminder systems have been successful in improving delivery of preventive services.

Introduction

Appropriate prenatal and postpartum care can have significant positive effects on both infant and maternal health. According to *The Medicaid Letter* of April 2000, recent studies indicate Medicaid recipients are more than twice as likely as those not enrolled in Medicaid to receive late or no prenatal care (36 percent versus 14 percent). A study examining the prenatal care of undocumented immigrants in California[9] noted that women who did not receive prenatal care were four times more likely to deliver low birth weight babies and seven times more likely to deliver premature babies compared with those women who received prenatal care. In its 2001 report on *The State of Managed Care Quality,*[4] the NCQA indicates that low birth weight babies are four times more likely to die prematurely than normal birth weight babies. The decrease in the length of maternal hospital stays reinforces the importance of postpartum visits to assess the physical health and emotional well-being of the new mother.

The American College of Obstetricians and Gynecologists recommends that women see their health care provider at least once between four and six weeks after giving birth. The first postpartum visit gives clinicians who care for new mothers the opportunity to conduct a physical examination and offer advice and assistance, including counseling on family planning and nutrition.

The Women's Care dimension includes the following HEDIS numerators:

- *Timeliness of Prenatal Care*
- *Postpartum Care*

Both of these numerators are components of the *Prenatal and Postpartum Care* measure, which examines whether perinatal care is available to pregnant women when needed and whether that care is provided in a timely manner. *Timeliness of Prenatal Care* was a new numerator in 2001, and results for 2000 were not available.

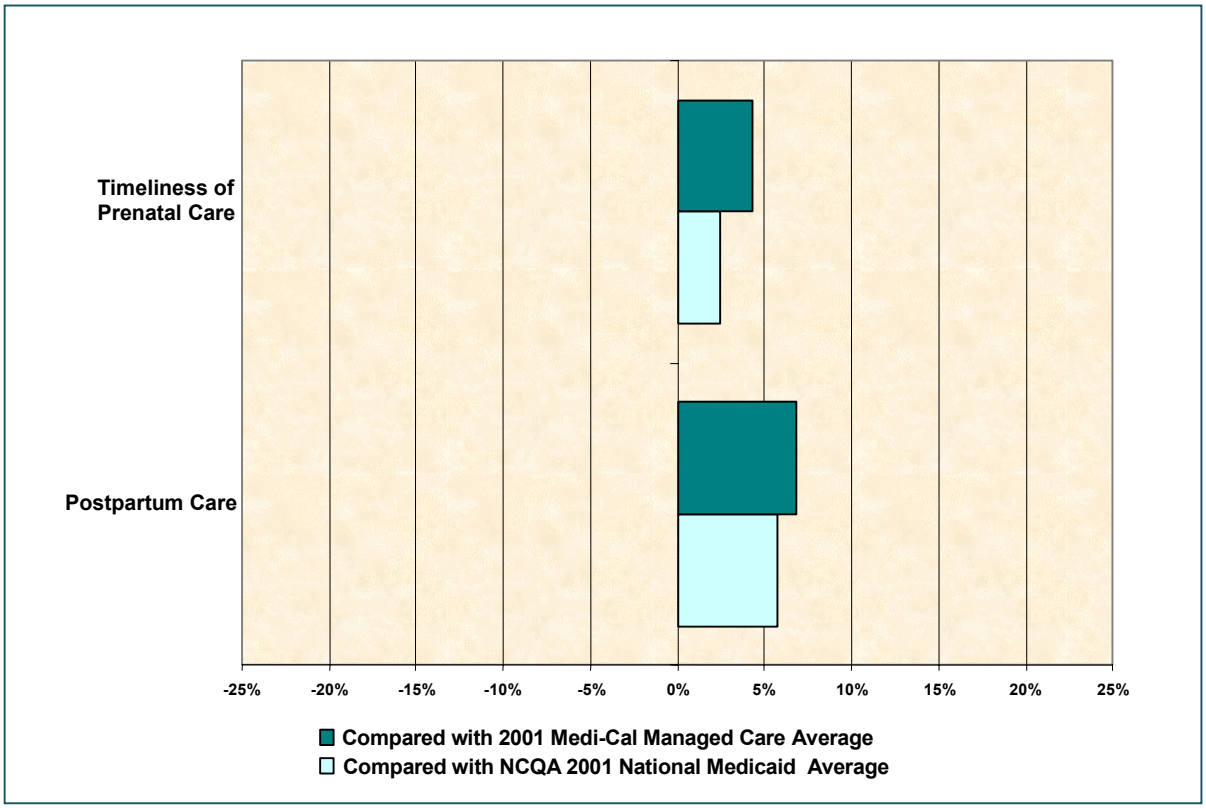
[9] Lu MC, Lin YG, Prietto NM, Garite TJ. Elimination of public funding of prenatal care for undocumented immigrants in California: A cost/benefit analysis. *Am J Obstet Gynecol*. January 2000;182:1.

Overall Average Rate Comparison for Women's Care

Figure 4-1 below illustrates these points:

- **Women's Care rates in 2002 have improved over the 2001 rates for both prenatal and postpartum care.**
- **There was an increase over the 2001 Medi-Cal managed care average for *Timeliness of Prenatal Care*.** Ten health plans representing 33 percent of the Medi-Cal managed care plans scored above the HPL, while none were below the MPL.
- **The 2002 Medi-Cal managed care average for *Postpartum Care* out-performed the NCQA 2001 national Medicaid averages**. The Medi-Cal managed care average for 2002 also exceeded the 2001 Medi-Cal managed care average. Five health plans (17 percent of the Medi-Cal managed care plans) scored above the HPL, and two were below the MPL.

Figure 4-1—2002 Medi-Cal Managed Care Plans:
Overall Average Rate Comparison for Women's Care



Interpretation

Comprehensive programs implemented by the health plans appear to have positively influenced the 2002 rates for the measures in the women's care dimension. Interventions to improve access to women's care and the implementation of health education programs were among the quality improvement activities contributing to higher 2002 rates. Medi-Cal managed care plans should continue activities that encourage prenatal care beginning early in the first trimester and ending with a postpartum visit within three to six weeks after giving birth.

Timeliness of Prenatal Care

Results

Two-thirds (20 out of 30) of the Medi-Cal managed care plans reported rates above the NCQA 2001 national Medicaid average of 70.9 percent, while one-third (10 out of 30) had rates above the HPL of 79.5 percent. None of the Medi-Cal managed care plans reported rates below the MPL for 2002.

When extrapolated to the entire eligible population of 40,622 members, the Medi-Cal managed care average of 73.4 percent implies 29,817 pregnant women received a timely prenatal care visit in 2002. Furthermore, if every Medi-Cal managed care plan were above the HPL in 2002, at least 2,477 additional pregnant women would have had a prenatal care visit in a timely manner.

Figure 4-2—2002 Medi-Cal Managed Care: Ranking for *Timeliness of Prenatal Care*

HEDIS Specification

This measure determines the percentage of women who delivered a live birth between November 6, 2000, and November 5, 2001, were continuously enrolled in the health plan for 43 days prior to delivery through 56 days after delivery, and who received a prenatal care visit in the first trimester or within 42 days of enrollment in the health plan.

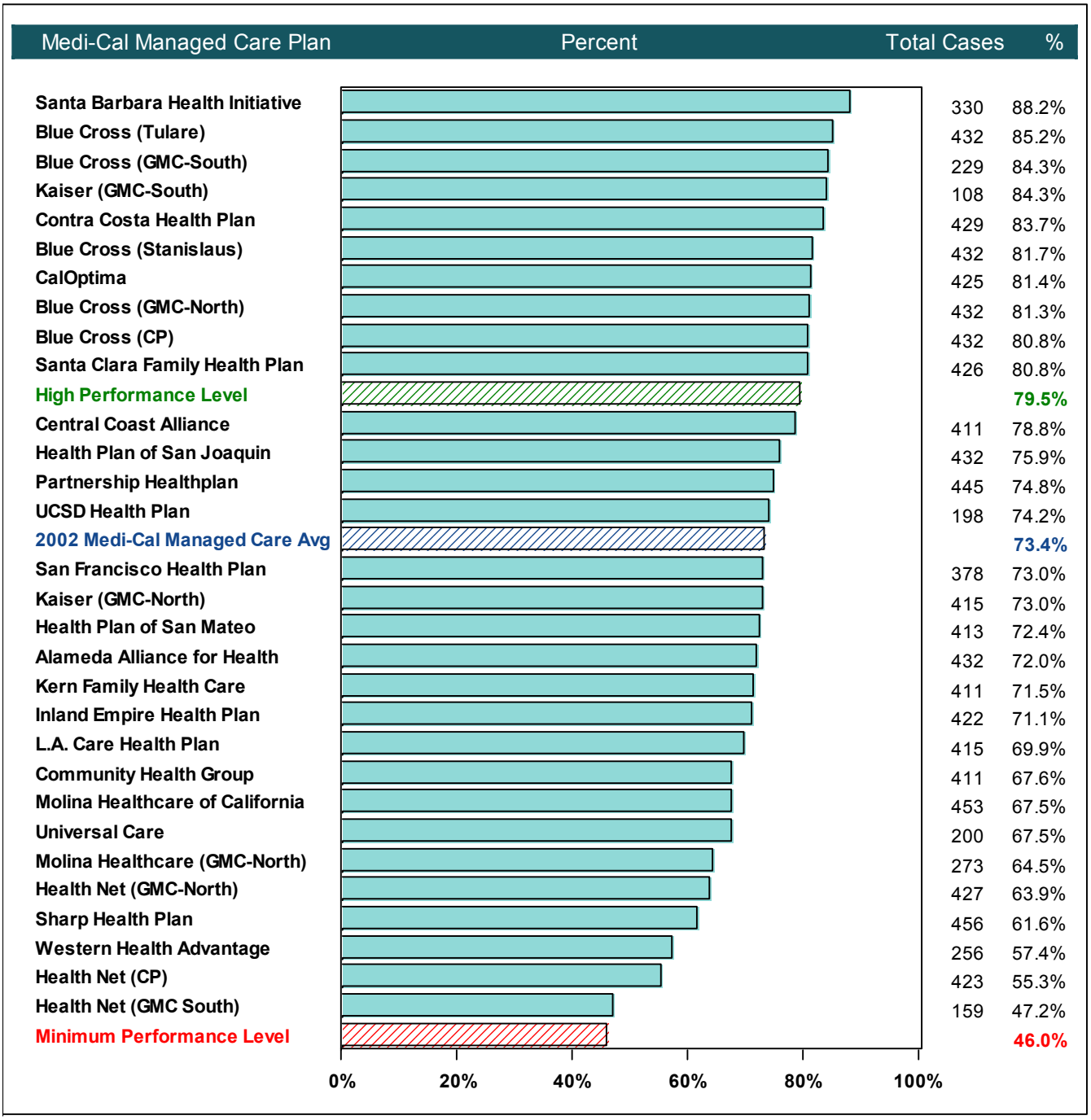
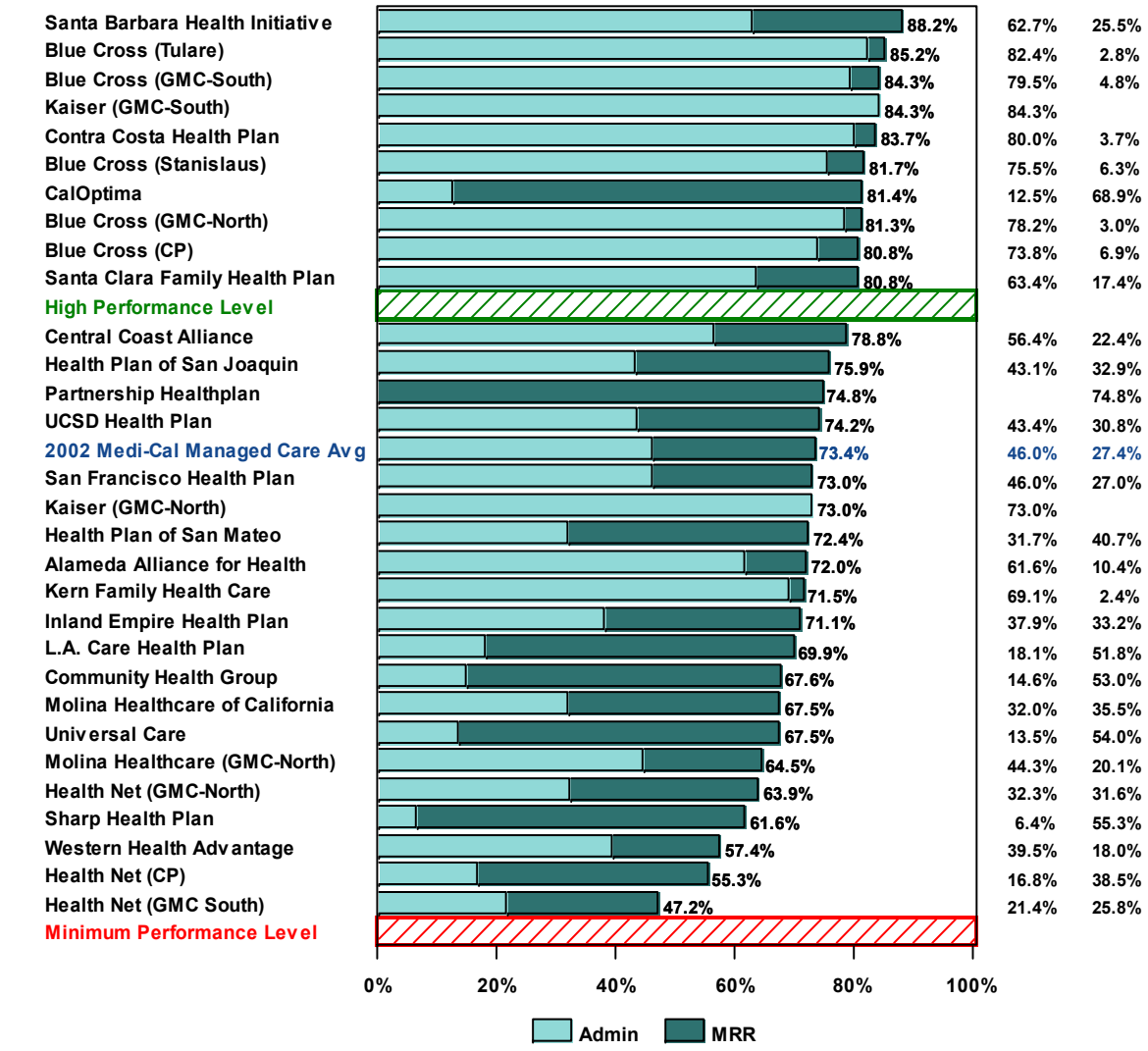


Figure 4-3—2002 Medi-Cal Managed Care: Administrative Data and Medical Record Review Rates for *Timeliness of Prenatal Care*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

Only Kaiser (GMC-North and South) elected to use the administrative methodology. The Medi-Cal managed care average for this measure was 73.4 percent. More than half of the Medi-Cal managed care average was derived from administrative data. For 70 percent (21 out of 30) of the Medi-Cal managed care plans, medical record review added more than 10.0 percentage points to the reported rates. Medical record review contributed 27.4 percentage points to the overall Medi-Cal managed care average.

These findings indicate the administrative data are not complete for this HEDIS measure and that most Medi-Cal managed care plans should continue to use the hybrid method to report their rates.

Figure 4-4—2002 Medi-Cal Managed Care Plans: 2001-2002 Trends for *Timeliness of Prenatal Care*

Medi-Cal Managed Care Plan	2001 (%)	2002 (%)
Santa Barbara Health Initiative	88.3	88.2
Blue Cross (Tulare)	65.7	85.2
Blue Cross (GMC-South)	79.8	84.3
Kaiser (GMC-South)	80.5	84.3
Contra Costa Health Plan	82.0	83.7
Blue Cross (Stanislaus)	78.7	81.7
CalOptima	69.8	81.4
Blue Cross (GMC-North)	76.3	81.3
Blue Cross (CP)	76.8	80.8
Santa Clara Family Health Plan	81.7	80.8
Central Coast Alliance	76.4	78.8
Health Plan of San Joaquin	65.0	75.9
Partnership Healthplan	76.6	74.8
UCSD Health Plan	81.3	74.2
Medi-Cal Managed Care Average	69.1	73.4
Kaiser (GMC-North)	70.8	73.0
San Francisco Health Plan	74.2	73.0
Health Plan of San Mateo	78.7	72.4
Alameda Alliance for Health	68.7	72.0
Kern Family Health Care	75.9	71.5
Inland Empire Health Plan	72.7	71.1
L.A. Care Health Plan	58.7	69.9
Community Health Group	69.6	67.6
Molina Healthcare of California	65.3	67.5
Universal Care	70.8	67.5
Molina Healthcare (GMC-North)	NA	64.5
Health Net (GMC-North)	34.9	63.9
Sharp Health Plan	NR	61.6
Western Health Advantage	57.9	57.4
Health Net (CP)	37.4	55.3
Health Net (GMC-South)	29.5	47.2

Note: The Timeliness of Prenatal Care measure was introduced in 2001. Therefore, no data are available for 1999 and 2000.

Trends

Two Medi-Cal managed care plans displayed considerable progress in 2002 compared with 2001. While Health Net (GMC-North) showed the largest year-to-year difference, with an increase of 29.0 percentage points (from a rate of 34.9 percent to 63.9 percent), there is still opportunity for improvement for this health plan. Blue Cross (Tulare) also increased substantially with an improvement of 19.5 percentage points (from a rate of 65.7 percent in 2001 to 85.2 percent in 2002), placing them well above the HPL of 79.5 percent. Eight Medi-Cal managed care plans improved their HEDIS rates by more than five percentage points over 2001.

UCSD Health Plan and the Health Plan of San Mateo had declines of more than five percentage points in their rates from 2001 to 2002.

Quality Improvement Efforts

Santa Barbara Health Initiative reported the highest rate for this measure in 2002, as was also the case in 2001. Santa Barbara Health Initiative's impressive rates can be attributed to the health plan's Comprehensive Perinatal Services Program. This comprehensive program includes health education, nutrition counseling, psychosocial assessments, and the implementation of appropriate interventions. The long-term goal of this program is to increase the percentage of women receiving prenatal care in the first trimester to 90.0 percent.

The Prenatal Program implemented by Blue Cross also appears to be effective in promoting early prenatal care. In all five of its contract-specific areas, Blue Cross had rates above the HPL of 79.5 percent. The Prenatal Program has been designed to identify members who are pregnant, encourage early and on-going prenatal care, and provide prenatal education. During each trimester, pregnant members are sent educational materials, breastfeeding information, immunization cards, and information about community-based classes. The Health Education department assists members with community class enrollment. Referrals are sent for case management when members are determined to be high-risk.

Please reference Appendix D for a detailed listing of *Timeliness of Prenatal Care* quality improvement efforts by individual Medi-Cal managed care plan.

Postpartum Care

The American College of Obstetricians and Gynecologists (ACOG) recommends that women see their health care provider at least once between four and six weeks after giving birth.[4] The first postpartum visit gives clinicians who care for new mothers the opportunity to conduct a physical examination and offer advice and assistance, including counseling on family planning and nutrition.

Results

The NCQA 2001 national Medicaid average of 47.9 percent was exceeded by 70.0 percent (21 out of 30) of the Medi-Cal managed care plans. The overall 2002 Medi-Cal managed care average of 53.6 percent represented a 6.8 percentage point improvement over the 2001 average of 46.8 percent. This was the first year the Medi-Cal managed care average was above the national Medicaid average.

Five Medi-Cal managed care plans (16.7 percent) exceeded the HPL of 61.0 percent, while two had rates below the MPL of 34.5 percent.

When extrapolated to the entire eligible population of 40,622 members, the Medi-Cal managed care average of 53.6 percent implies 21,773 women received a postpartum care visit in 2002. Furthermore, if every Medi-Cal managed care plan were above the HPL in 2002, a minimum of 3,006 additional women would have received a postpartum care visit.

Figure 4-5—Medi-Cal Managed Care Plans: Ranking for *Postpartum Care*

HEDIS Specification

This measure determines the percentage of women who delivered a live birth between November 6, 2000, and November 5, 2001, were continuously enrolled in the health plan for 43 days prior to delivery through 56 days after delivery, and who received a postpartum visit on or between 21 days and 56 days after delivery.

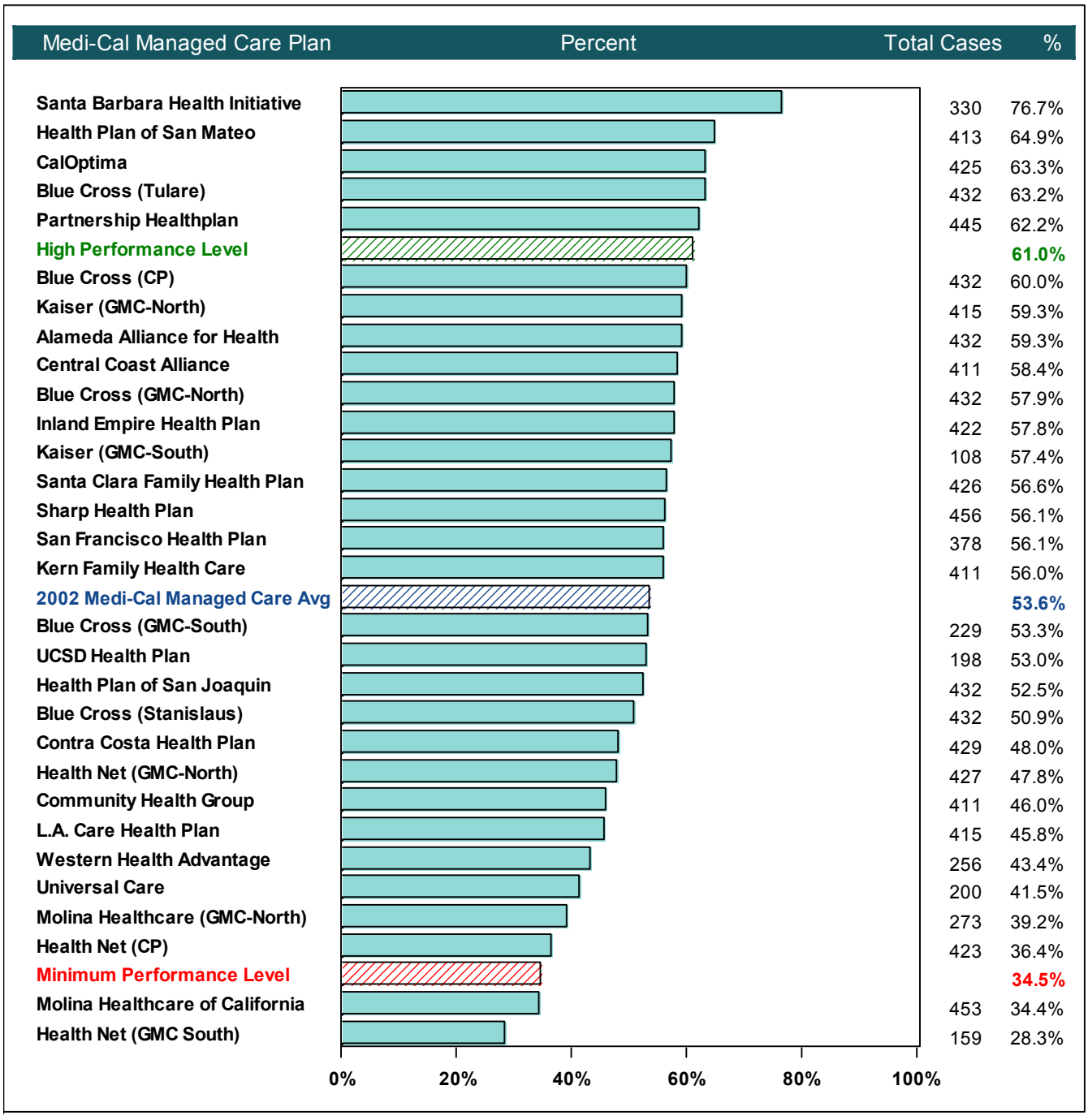
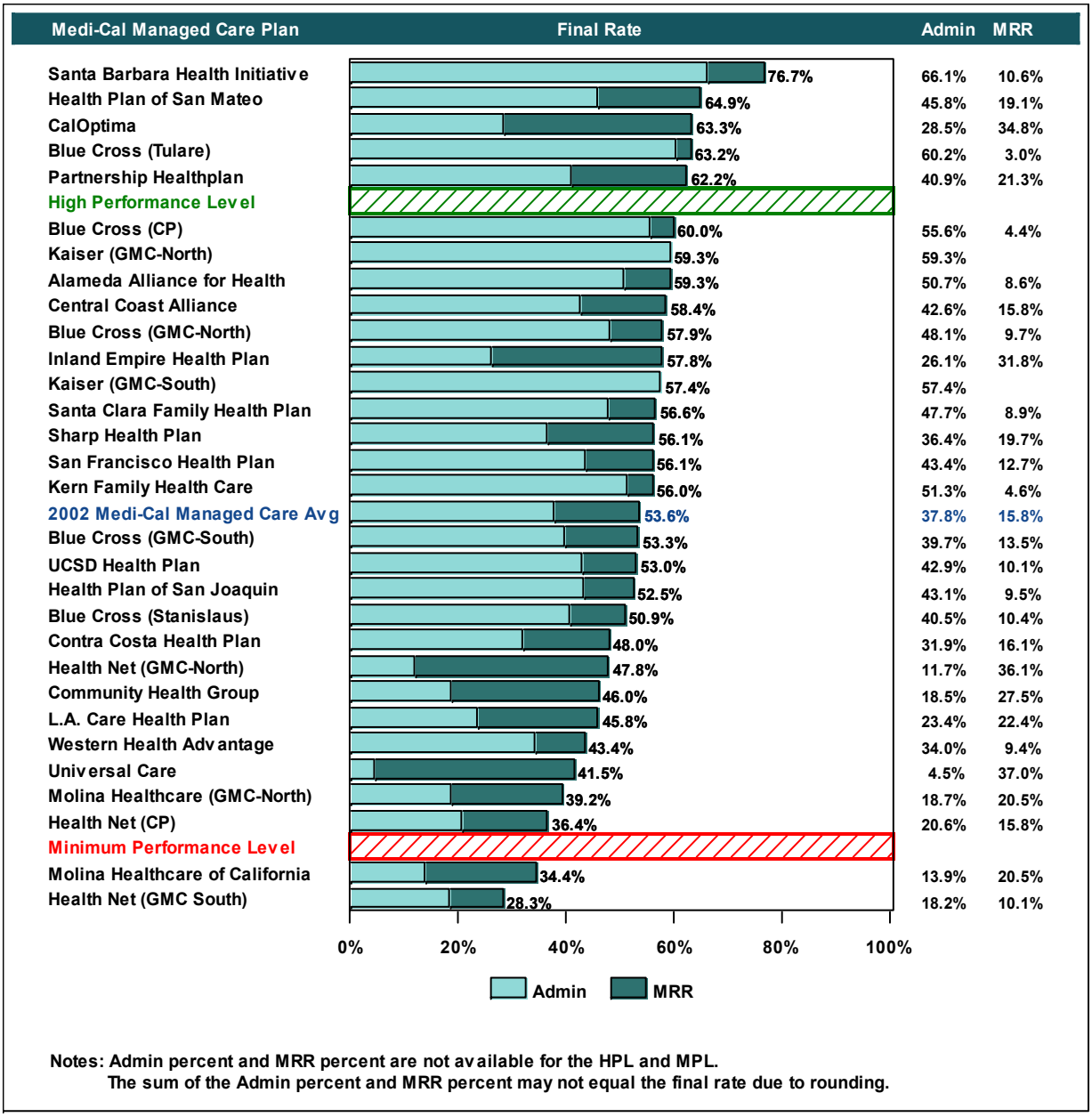


Figure 4-6—Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Postpartum Care*



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

Kaiser (GMC-North and South) elected to use the administrative methodology. The Medi-Cal managed care average for this measure was 53.6 percent. The majority of the Medi-Cal managed care average was derived from administrative data. Two-thirds (20 out of 30) of the Medi-Cal managed care plans improved their rates by more than 10.0 percentage points using medical record review. Overall, the 2002 Medi-Cal managed care average increased 15.8 percentage points by using medical record review to supplement the administrative rate.

These findings indicate the administrative data are not complete for this HEDIS measure and most Medi-Cal managed care plans should continue to use the hybrid method to report their rates.

Figure 4-7—Medi-Cal Managed Care Plans: 1999-2002 Trends for *Postpartum Care*

Medi-Cal Managed Care Plan	1999 (%)	2000 (%)	2001 (%)	2002 (%)
Santa Barbara Health Initiative	69.9	71.4	74.9	76.7
Health Plan of San Mateo	54	63.7	65.7	64.9
CalOptima	44.4	44.5	52.7	63.3
Blue Cross (Tulare)	NA	49.9	47.5	63.2
Partnership Healthplan	53.5	53.2	56.8	62.2
Blue Cross (CP)	55.6	54.8	53.4	60.0
Alameda Alliance for Health	36.4	42.9	40.9	59.3
Kaiser (GMC-North)	NR	53.6	56.0	59.3
Central Coast Alliance	39	57.8	55.2	58.4
Blue Cross (GMC-North)	57.6	56.3	55.5	57.9
Inland Empire Health Plan	40.4	40.7	50.0	57.8
Kaiser (GMC-South)	NA	67.3	57.6	57.4
Santa Clara Family Health Plan	41.5	56.3	53.1	56.6
San Francisco Health Plan	61.4	44.5	48.3	56.1
Sharp Health Plan	NA	20.2	34.2	56.1
Kern Family Health Care	56.5	54.5	55.1	56.0
Medi-Cal Managed Care Average	46.2	46.5	46.8	53.6
Blue Cross (GMC-South)	NA	41.4	48.9	53.3
UCSD Health Plan	NA	NA	66.4	53.0
Health Plan of San Joaquin	42.5	44.1	38.3	52.5
Blue Cross (Stanislaus)	50.9	51.4	50.9	50.9
Contra Costa Health Plan	32.6	33.0	45.7	48.0
Health Net (GMC-North)	35.9	46.6	22.1	47.8
Community Health Group	NA	34.8	46.7	46.0
L.A. Care Health Plan	38.4	41.2	45.2	45.8
Western Health Advantage	33	44.2	42.9	43.4
Universal Care	NA	44.6	29.9	41.5
Molina Healthcare (GMC-North)	NA	NA	NA	39.2
Health Net (CP)	37.8	42.6	28.2	36.4
Molina Healthcare of California	14	15.3	26.2	34.4
Health Net (GMC-South)	NA	NA	15.2	28.3

Trends

The *Postpartum Care* rates for 46.7 percent of the Medi-Cal managed care plans (14 out of 30) improved by more than five percentage points over 2001, and eight of those Medi-Cal managed care plans achieved improvements of more than 10.0 percentage points.

Only UCSD Health Plan had a decline of more than five percentage points in its rate between 2001 and 2002.

Both Molina Healthcare of California and Health Net (GMC-South) had rates below the MPL of 34.5 percent. However, Molina Healthcare of California has shown substantial improvement with a rate of 34.4 percent in 2002 compared with 15.3 percent in 2000. In addition, Health Net (GMC-South) did not have an available rate in 2000 and increased from 15.2 percent in 2001 to a reported rate of 28.3 percent in 2002.

Quality Improvement Efforts

For the third consecutive year, the *Postpartum Care* rates for Santa Barbara Health Initiative and Health Plan of San Mateo exceeded the HPL rate of 61.0 percent. The majority of the Medi-Cal managed care plans showed improvement over the previous year. The following is a summary of the quality improvements undertaken by the Medi-Cal managed care plans over the past year:

- Provider education efforts increased and included recommendations of services for women before and after delivery. One health plan designed a form that included all elements necessary for documentation of a positive postpartum exam. The forms were distributed to obstetrician (OB) physician offices.
- Encounter data submission was improved by the initiation of a provider incentive program.
- Specialized programs that focused on care provided to women during pregnancy and continued through postpartum care were created. All pregnant members were given a car seat and were eligible to receive gifts when they had their postpartum visit.
- Information that recommended prenatal and postpartum services was mailed to members.
- One Medi-Cal managed care plan worked with hospitals, so that hospitals would notify the health plan when a member was admitted for delivery. A nurse from the health plan then met with the mother and discussed postpartum care. Reminder postcards with the actual range of dates when postpartum visits were needed were then sent to the member and the provider.

Please reference Appendix D for a detailed listing of *Postpartum Care* quality improvement efforts by individual Medi-Cal managed care plan.

Women's Care Summary

This was the second year for reporting *Timeliness of Prenatal Care*. Nevertheless, the Medi-Cal managed care average of 73.4 percent for *Timeliness of Prenatal Care* was above the NCQA 2001 national Medicaid average of 70.9 percent. Ten Medi-Cal managed care plans reported rates above the HPL of 79.5 percent, while none were below the established MPL of 46.0 percent.

For *Postpartum Care*, the NCQA 2001 national Medicaid average of 47.9 percent was exceeded by 70.0 percent of the Medi-Cal managed care plans in 2002. Five Medi-Cal managed care plans were above the HPL, while two were below the MPL.

Identifying the denominator for this measure requires administrative data. Inpatient data may come from several facilities, and must be monitored for its accuracy and completeness. Medical record review is often difficult to perform for this measure, and requires complete provider information.

Women's Care Recommendations

Implement or Continue Perinatal Quality Improvement Programs

- The Medi-Cal managed care plans should consider implementing or continuing quality improvement projects associated with prenatal and postpartum care. In addition to increased member and provider education activities, the use of reminder cards for postpartum care visits has been found to be effective.

Use the Hybrid Method of Data Collection for This Measure

- The findings for both *Timeliness of Prenatal Care* and *Postpartum Care* suggest the Medi-Cal managed care plans do not capture administratively all prenatal and postpartum care visits, and therefore, the hybrid method should continue to be utilized.

Address Global Billing Issues

- Global billing and capitation of maternal related services are practices that often affect the *Timeliness of Prenatal Care* and *Postpartum Care* measures. Medi-Cal managed care plans may want to explore incentives for providers to submit all maternal related encounter data with the required elements to be used in HEDIS (e.g., dates of service for prenatal and postpartum visits on a global bill).

Ensure Accuracy and Completeness of Provider Data

- The Medi-Cal managed care plans should continue to maintain complete, updated, and accurate provider data. This is important for medical record pursuit and review since women often access other providers besides their primary care provider for services related to maternity care.

Continue Encounter Data Completeness Efforts

- The Medi-Cal managed care plans should continue to collect, monitor, and integrate their claims/encounter transaction data from providers and external vendors. The *Prenatal Care and Postpartum Care* measure relies on claims/encounter data to accurately and completely identify the denominator. Collecting data from providers and external vendors must also be accompanied with oversight of their data completeness and accuracy.

Continue Provider Education Initiatives That Encourage Use of Nationally Approved Guidelines

- Provider education efforts should include recommendations endorsed by ACOG for the initiation of prenatal care as well as postpartum care.

Introduction

Chronic illness afflicts a great number of people in the United States and accounts for a large proportion of health care expenditures. Health plans must be able to identify members with chronic conditions, treat these members appropriately and then monitor members' ongoing preventive care. By doing so, health plans can not only help to contain costs, but also can help improve the quality of life for these individuals by assisting them to take care of themselves, minimizing adverse health effects associated with these chronic conditions, avoiding complications, and maintaining daily activities.

The *Living with Illness* dimension is comprised of two HEDIS measures:

- *Eye Exams for People with Diabetes* (COHS health plans only)
- *Use of Appropriate Medications for People with Asthma*

Overall Average Rate Comparison for Living With Illness

Eye Exams for People with Diabetes rates were reported by each of the five County Organized Health Systems (COHS) in place of the *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* measure. All the COHS health plans demonstrated good performance in 2002 for this measure.

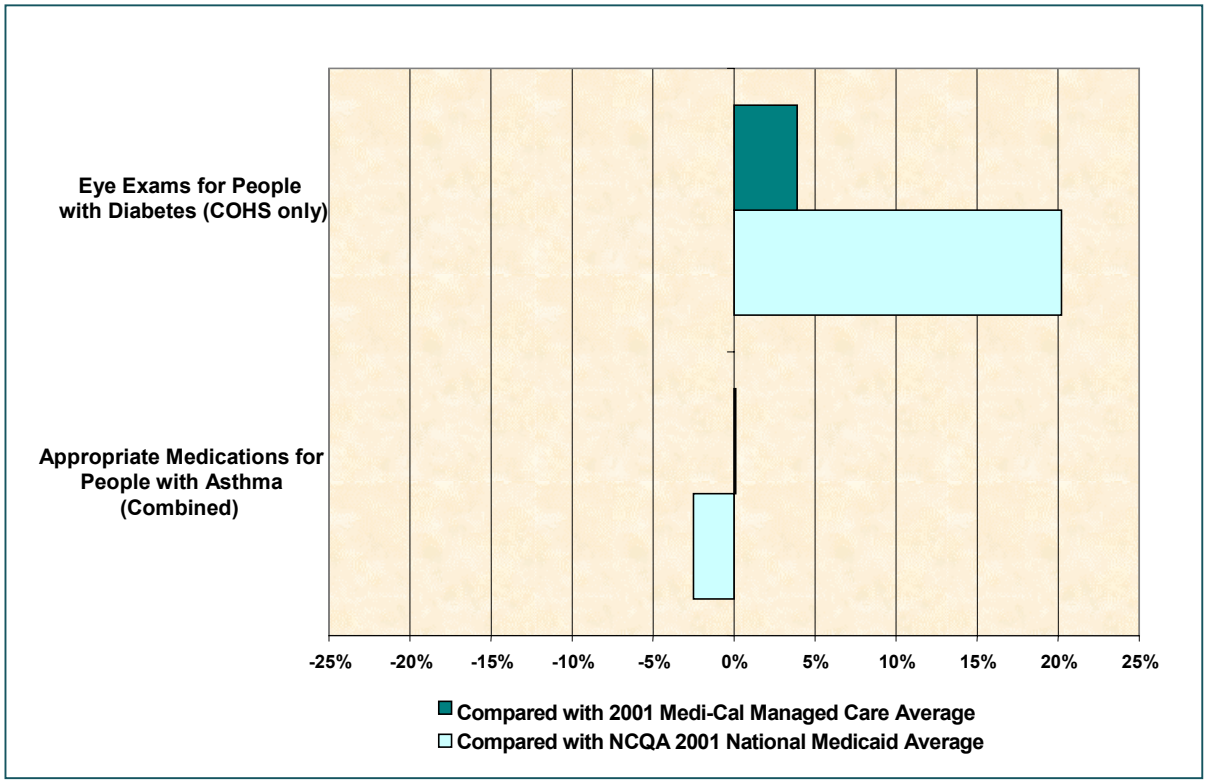
The *Use of Appropriate Medications for People with Asthma* appears to be a measure that may provide an opportunity for improvement for several Medi-Cal managed care plans. Five health plans were above the HPL of 64.9 percent, three were below the MPL of 44.9 percent.

In 2002, NCQA updated the list of appropriate medications for people with asthma to include additional medications. Nationally, the addition of these medications improved the HEDIS rates. However, not all of the Medi-Cal managed care plans benefited from this change (i.e., health plans may not dispense some or all of the additional medications and, therefore, rates would be less likely to improve).

Figure 5-1 below illustrates these points:

- **The 2002 Medi-Cal managed care average for *Eye Exams for People with Diabetes* is higher than the 2001 Medi-Cal managed care average, and more than 20 percentage points higher than the NCQA 2001 national Medicaid average.**
- **For the *Use of Appropriate Medications for People with Asthma* measure, the 2002 Medi-Cal managed care average is virtually the same as the 2001 Medi-Cal managed care average, and slightly lower than the NCQA 2002 national Medicaid average of 57.1 percent.**

Figure 5-1—2002 Medi-Cal Managed Care Plans: Overall Average Rate Comparison for Living with Illness



Interpretation

The two health plans with the highest rates for *Eye Exams for People with Diabetes* have a diabetes quality improvement program in place. Similarly, the Medi-Cal managed care plans with focused asthma quality improvement programs showed greater improvement in the *Use of Appropriate Medications for People with Asthma* measure in 2002.

The effectiveness of these programs is demonstrated by the improvement in rates for these health plans. Continuation of these programs is strongly encouraged, as is initiation of similar disease management activities for those health plans that do not currently have targeted quality improvement programs in place.

Eye Exams for People with Diabetes (COHS Health Plans Only)

Diabetes is one of the most costly and prevalent chronic diseases in the United States. Approximately 16 million Americans have diabetes, with 798,000 new cases diagnosed annually. Proper management of diabetes significantly reduces the rate of complications and improves quality of life for diabetics. The World Health Organization (WHO) estimates that the total health care costs of persons with diabetes in the United States are three times higher than those for people without the condition.[4]

Diabetic retinopathy is one of the most common complications associated with diabetes and the leading cause of blindness among working-age Americans, causing up to 24,000 new cases of blindness every year. Studies such as the Diabetes Control and Complications Trial (DCCT) have established that intensive diabetes management at an early stage can prevent and delay the progression of diabetic retinopathy.[10]

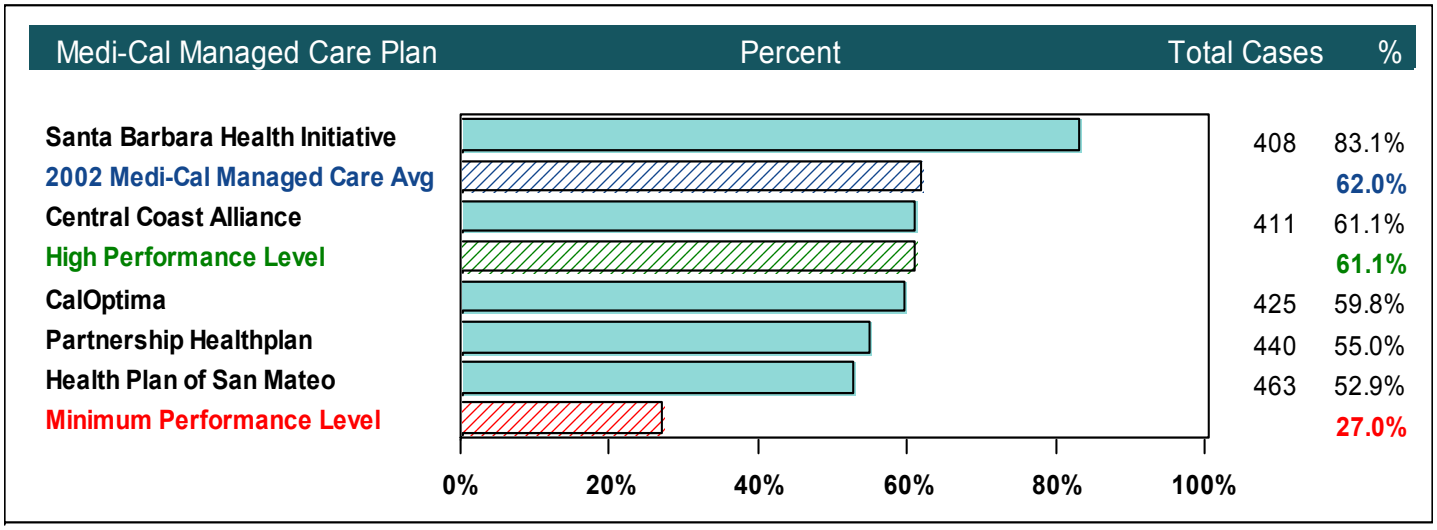
The COHS plans provide coverage to the aged, blind and disabled populations enrolled in Medi-Cal, and therefore have a higher proportion of older members and more members with at least one chronic condition. For this reason, the COHS plans are required to report the HEDIS measure *Eye Exams for People with Diabetes* in place of *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* measure.

[10] New England Journal of Medicine. September 1993; 329 (14).

Figure 5-2—2002 Medi-Cal Managed Care Plans: Ranking for *Eye Exams for People with Diabetes* (COHS Health Plans Only)

HEDIS Specification

This measure determines the percentage of diabetics who had an eye exam in the measurement year by an eye care professional (optometrist or ophthalmologist), as documented either through administrative data or medical record review. Health plans may also count toward the numerator event an eye exam performed in the year prior to the measurement year provided certain criteria are met.

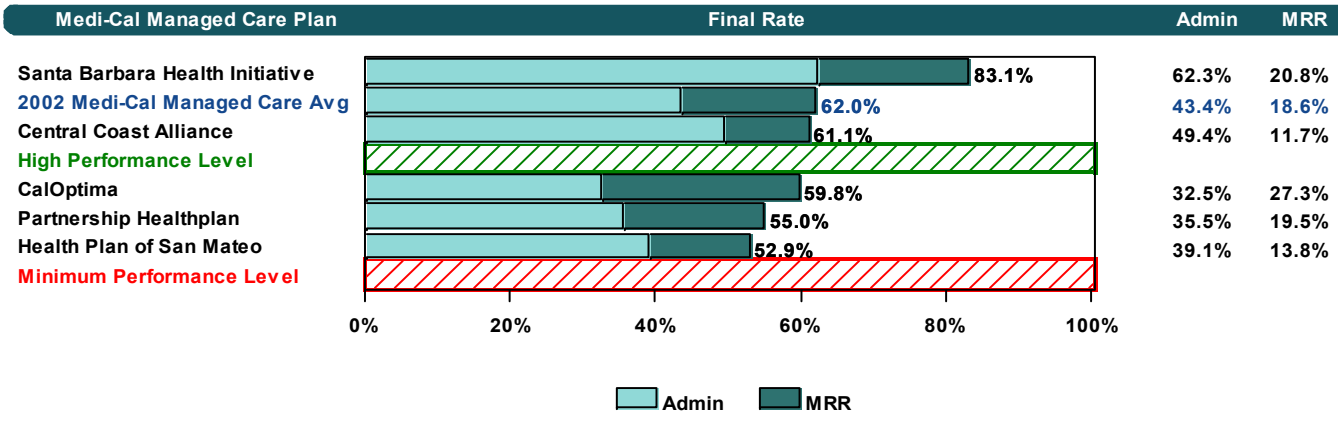


Results

All five COHS health plans exceeded the NCQA 2001 national Medicaid average of 41.8 percent for this measure, and none were below the MPL of 26.6 percent. Two plans met or exceeded the HPL of 61.1 percent, and the overall average for the COHS health plans was 62.0 percent.

When extrapolated to the entire eligible population of 16,875 members, the overall average for the COHS health plans of 62.0 percent implies 10,463 members with diabetes received an eye exam in 2002. This overall average is already above the HPL. However, if the three individual plans with rates below the HPL in 2002 improved to 61.1 percent, an additional 370 members with diabetes would have received eye exams.

Figure 5-3—2002 Medi-Cal Managed Care Plans: Administrative Data and Medical Record Review Rates for *Eye Exams for People with Diabetes* (COHS Health Plans Only)



Notes: Admin percent and MRR percent are not available for the HPL and MPL.
The sum of the Admin percent and MRR percent may not equal the final rate due to rounding.

Data Collection Methods

All of the COHS health plans elected to use the hybrid reporting methodology for this measure. The Medi-Cal managed care average for this measure was 62.0 percent. Overall, the 2002 Medi-Cal managed care average increased 18.6 percentage points using medical record review.

These findings imply the administrative data are not fully complete for this HEDIS measure and the COHS health plans should continue to use the hybrid method to report their rates.

Figure 5-4—2002 Medi-Cal Managed Care Plans: 1999-2002 Trends for *Eye Exams for People with Diabetes* (COHS Health Plans Only)

Medi-Cal Managed Care Plan	1999 (%)	2000 (%)	2001 (%)	2002 (%)
Santa Barbara Health Initiative	52.0	68.7	75.4	83.1
Medi-Cal Managed Care Average	41.3	53.1	58.1	62.0
Central Coast Alliance	18.0	29.4	54.5	61.1
CalOptima	35.2	47.7	45.7	59.8
Partnership Healthplan	49.9	56.6	58.2	55.0
Health Plan of San Mateo	49.2	61.9	57.4	52.9

Trends

Overall, the COHS health plans' average rate has steadily increased from 53.1 percent in 2000 to 62.0 percent in 2002.

Rates for CalOptima increased by more than 14.0 percentage points in 2002 alone, showing a remarkable recovery after a small decline in 2001. For Santa Barbara Health Initiative and Central Coast Alliance, rates showed improvement in both 2001 and 2002, while for the Health Plan of San Mateo, rates declined in both 2001 and 2002.

Quality Improvement Efforts

Santa Barbara Health Initiative and Central Coast Alliance both have reported steady year-to-year improvement in the rate of *Eye Exams for People with Diabetes*. These two plans utilized the following strategies and, in 2001, attributed the improvement in their rates to the following quality improvement efforts:

- Reports sent to the high-volume providers each month showed preventive care utilization rates for the various HEDIS indicators for diabetes. A nurse in charge of this process then met with low-performing providers on a quarterly basis.
- Financial incentives were given to providers for completing tests on diabetic members and for showing improvement in outcomes, such as lower HbA1c levels in these members. The HBA1c test (hemoglobin A1c test or glycosylated hemoglobin test) is a laboratory test that reveals average blood glucose over a period of two to three months. Controlling blood glucose levels in people with diabetes improves their quality of life and decreases health care utilization since uncontrolled blood glucose levels can lead to blindness, end-stage renal disease, and amputation of lower extremities.
- Santa Barbara Health Initiative had an Internal Quality Improvement Project (IQIP) on diabetes. Its Diabetes Smart (**S**uccessful **M**anagement **A**lways **R**equires a **T**eam) program has been in operation since 1999. All members with Type I, Type II, or gestational diabetes were encouraged to seek appropriate care through this disease management program, and physicians were encouraged to routinely refer every member with diabetes to the program.
- A department was created with direct responsibility for oversight of the entire HEDIS data collection and reporting process.
- HEDIS experience was applied to develop strategies for the enhancement of data collection capabilities and medical record pursuit.

Please reference Appendix D for a detailed listing of *Eye Exams for People with Diabetes* quality improvement efforts by individual Medi-Cal managed care plan.

Use of Appropriate Medications for People with Asthma

Asthma accounts for more than 10 million physician visits, 400,000 hospitalizations, 1 million emergency room (ER) visits and approximately 10 million missed school days annually. It is the most common chronic condition in children and the sixth most common chronic condition overall in the United States, with 5 million children and 12 million adults affected.[4]

The incidence of asthma is highest among children and persons/families with lower income levels. Nearly 3 million Californians experienced asthma symptoms in 2001, a prevalence rate of 8.8 percent.[11] This is significantly higher than the national prevalence rate of 5.5 percent. Using the 8.8 percent rate, a conservative estimate of the number of asthmatics in the Medi-Cal managed care population can be derived. There are over 260,000 people in the Medi-Cal managed care population who experienced asthma symptoms in 2001.

The HEDIS measure, *Use of Appropriate Medications for People with Asthma*, is designed to evaluate whether members with persistent asthma are being prescribed medications acceptable as primary therapy for long-term control of asthma.

Results

The NCQA 2001 national Medicaid average of 57.1 percent was exceeded by 58.6 percent (17 out of 29) of the reporting Medi-Cal managed care plans.

The HPL of 64.9 percent was exceeded by five out of 29 plans (17.2 percent). Contra Costa Health Plan achieved the highest rate, at 85.3 percent, which was 16.4 percentage points higher than the second ranked plan. Three plans reported rates below the MPL of 44.9 percent.

This measure uses the entire eligible population (i.e., no sampling was allowed) and does not require extrapolation of the results. Note that 1 of the 30 managed care plans did not have any eligible members for this measure.

Data Collection Methods

NCQA requires all health plans to report this measure using the administrative method; the hybrid method is not allowed.

[11]Brown ER, Meng YY, Babey SH, Malcom E. *Asthma in California in 2001: High Rates Affect Most Population Groups*. Los Angeles: California Health Interview Survey Policy Brief, UCLA Center for Health Policy Research. May 2002.

Figure 5-5—2002 Medi-Cal Managed Care Plans: Ranking for *Use of Appropriate Medications for People with Asthma* (Combined Rate)

HEDIS Specifications

This measure evaluates whether members with persistent asthma are being prescribed medications acceptable as primary therapy for long-term control of asthma. The measure is a claims-based denominator and is reported using the administrative method only. Members are identified based on age (5 to 56 years of age), a two-year continuous enrollment criteria, and a requirement of being identified as having *"persistent asthma."*

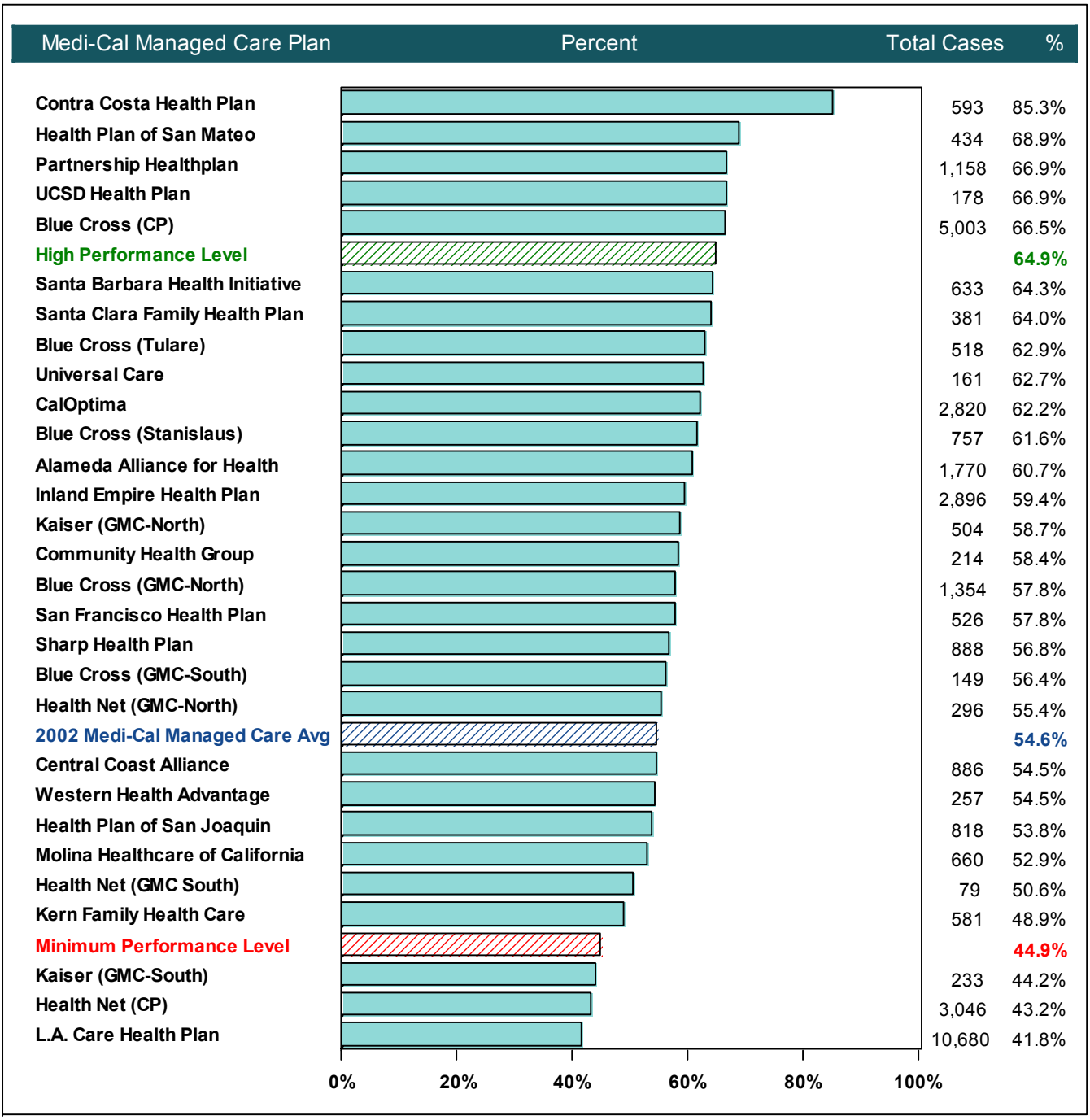


Figure 5-6—2002 Medi-Cal Managed Care Plans: 2001-2002 Trends for *Use of Appropriate Medications for People with Asthma* (Combined Rate)

Medi-Cal Managed Care Plan	2001 %	2002 %
Contra Costa Health Plan	49.6	85.3
Health Plan of San Mateo	57.5	68.9
Partnership Healthplan	64.6	66.9
UCSD Health Plan	66.1	66.9
Blue Cross (CP)	56.0	66.5
Santa Barbara Health Initiative	58.0	64.3
Santa Clara Family Health Plan	51.6	64.0
Blue Cross (Tulare)	NA	62.9
Universal Care	55.9	62.7
CalOptima	67.2	62.2
Blue Cross (Stanislaus)	54.9	61.6
Alameda Alliance for Health	36.1	60.7
Inland Empire Health Plan	55.7	59.4
Kaiser (GMC-North)	54.1	58.7
Community Health Group	56.5	58.4
Blue Cross (GMC-North)	49.2	57.8
San Francisco Health Plan	59.0	57.8
Sharp Health Plan	50.0	56.8
Blue Cross (GMC-South)	50.7	56.4
Health Net (GMC-North)	48.9	55.4
Medi-Cal Managed Care Average	54.5	54.6
Central Coast Alliance	55.2	54.5
Western Health Advantage	52.0	54.5
Health Plan of San Joaquin	83.5	53.8
Molina Healthcare of California	51.9	52.9
Health Net (GMC-South)	47.5	50.6
Kern Family Health Care	85.3	48.9
Kaiser (GMC-South)	NR	44.2
Health Net (CP)	45.0	43.2
L.A. Care Health Plan	49.3	41.8
Molina Healthcare (GMC-North)	NA	NA

Note: The *Use of Appropriate Medications for People with Asthma* measure was introduced in 2001. Therefore, no data are available for 1999 and 2000.

Trends

Comparing 2001 with 2002, combined rates increased for 20 managed care plans, five of them by more than 10.0 percentage points, while rates for two managed care plans declined by more than 10.0 percentage points.

Contra Costa Health Plan showed the largest year-to-year difference, with a rate increase of 35.7 percentage points from 49.6 percent to 85.3 percent, and for Alameda Alliance for Health the rate increased 24.6 percentage points from 36.1 percent to 60.7 percent.

In contrast, the combined rate for Kern Family Health Care declined 36.4 percentage points, from 85.3 percent to 48.9 percent, and for Health Plan of San Joaquin the rate declined 29.7 percentage points, from 83.5 percent to 53.8 percent.

Quality Improvement Efforts

In 1999, Contra Costa Health Plan initiated an IQIP on adult asthma management. The IQIP goal was to implement interventions geared toward assisting asthmatic members with self-management of their disease, with the aim of improving self-reported functional status, satisfaction with care, and the members' ability to modify their medication usage according to symptoms. The plan established an Asthma Management Team, which worked closely with FAACT to develop a methodology for case finding and baseline evaluation of adult asthmatics. The health plan obtained asthma patient lists from emergency rooms and entered patients into a case management program. The case manager telephoned or visited patients and provided education on managing asthma and how to deal with asthma triggers in the environment.

The rates for Blue Cross (four of the five contract-specific areas) also showed improvement. Blue Cross instituted the following quality improvement efforts related to asthma care:

- Distributed Asthma Clinical Practice Guidelines to primary care practitioners (PCPs);
- Faxed lists to PCPs identifying asthmatic members and requested confirmation of diagnosis;
- Conducted one-on-one member/pharmacist consultation;
- Distributed asthma kits, including peak flow meter, spacers, asthma diary, and educational materials; and
- Sent quarterly newsletter to members in program.

Please reference Appendix D for a detailed listing of *Use of Appropriate Medications for People with Asthma* quality improvement efforts by individual Medi-Cal managed care plan.

Living With Illness Summary

For *Eye Exams for People with Diabetes*, the Medi-Cal managed care average has steadily increased from 53.1 percent in 2000 to 62.0 percent in 2002. The Medi-Cal managed care average has consistently been above the national Medicaid average. The Medi-Cal managed care average of 62.0 percent for 2002 was above the HPL of 61.1 percent.

This was the second year the Medi-Cal managed care plans reported a rate for the *Use of Appropriate Medications for People with Asthma*. The 2002 Medi-Cal managed care average of 54.6 percent was less than 3 percentage points below the NCQA 2001 national Medicaid average of 57.1 percent. The NCQA 2001 national Medicaid average of 57.1 percent was exceeded by 58.6 percent (17 out of 29) of the reporting plans.

Living With Illness Recommendations

Maintain or Begin Diabetic Disease Management Programs

- The COHS health plans should initiate or continue existing disease management programs with a focus on diabetes. The large improvement seen in the COHS health plans with focused diabetes disease management activities reinforces the value of these efforts.

Maintain or Begin Asthma Quality Improvement Programs

- The Medi-Cal managed care plans with existing asthma disease management programs should be encouraged to continue their programs. Those health plans with asthmatic members should seriously consider developing a program. The large improvement seen in the managed care plans with focused asthma disease management activities reinforces the value of these efforts.

Continue Efforts to Improve Encounter Data Completeness

- Medi-Cal managed care plans should continue to collect, monitor, and integrate their claims/encounter transaction data from providers and external vendors. Both of the Living With Illness measures rely on claims/encounter and pharmacy data to accurately and completely identify the denominator. Collecting data from providers and external vendors must be accompanied with diligent monitoring of submitted data for completeness and accuracy.
- Appropriate follow-up for those providers who do not submit complete encounter data on a timely basis is essential.

Introduction

DHS requires each Medi-Cal managed care plan to undergo a NCQA HEDIS Compliance Audit of its reported HEDIS data. Each health plan is responsible for HEDIS data collection and measure generation and must use a licensed independent audit firm to conduct the audit. Audited data can be used to compare health plan performance against other Medi-Cal managed care plans and national Medicaid benchmarks. For this section of the report, HSAG conducted a thorough review of the HEDIS Compliance Audit™ reports for each health plan. Data from these reports were collected and compiled to identify common issues that challenge the Medi-Cal managed care plans and may limit their ability to collect and report HEDIS data.

When discussing systemic issues identified from the HEDIS Compliance Audit process, the issues are reported at the health plan level, rather than the contract-specific level. Although a health plan may report HEDIS rates for several different areas (i.e. counties or contracts), the processes in place for collecting and reporting HEDIS data typically do not differ between the reporting units.

Overall HEDIS Data Collection and Reporting Performance

This is the fourth year that Medi-Cal managed care plans have collected and reported HEDIS data to DHS. It is important to note that over these four years, the health plans have matured in their processes and infrastructure needed to support HEDIS reporting. Evidence that Medi-Cal managed care plans' infrastructure has matured include the following:

- The majority of the health plans have staff experienced with HEDIS data collection and reporting.
- Each year health plans build on the programming efforts and experience from previous years.
- Implemented interventions were effective in making HEDIS data collection and reporting more efficient.
- Sophistication of processes for manual data collection (medical record review) processes increases each year.

Generally, the health plans have increased their HEDIS expertise. This improvement in the supportive systems and processes for collecting and reporting HEDIS data is evident by the small number of "Not Report" audit designations for the DHS External Accountability Set measures. Overall, the Medi-Cal managed care plans have the capability to report the selected measures.

Some health plans have improved HEDIS data collection and reporting by using a certified software vendor for measure generation. Seven Medi-Cal managed care plans contracted with vendors that underwent software certification by NCQA to generate the necessary HEDIS measures. This approach to HEDIS reporting adds more consistency to HEDIS measure generation and alleviates some of the burden of source code creation on the contracting health plan.

Overall Findings

Global Billing Practices

Auditors cited nine health plans as practicing global billing for maternity-related services. Global billing occurs when a provider submits one bill that encompasses all services rendered throughout the pregnancy, including postpartum visits. Global billing processes may cause:

- Difficulty in determining the date of delivery;
- Difficulty in determining when and which services were provided to the pregnant woman; and
- Difficulty in determining which maternity measure(s) the member is eligible for due to continuous enrollment criteria.

The end result is that health plans must establish processes to appropriately identify the delivery date to avoid an increased reliance on medical record review.

Data Completeness

The HEDIS auditors cited data completeness issues in seven health plans. Data completeness is a general term that represents an evaluation of how complete a health plan's claims/encounter database is compared against the true volume of services rendered. Data completeness affects both numerator and denominator accuracy. Claims/encounter transaction data are necessary for numerator generation, and for some measures, for denominator generation. Complete transaction data most often will increase the plan's HEDIS rates in addition to giving a more accurate reflection of the care and services being rendered. Manual data collection (medical record review), when permissible, is one way that plans may compensate for the lack of transaction data. Another way is to utilize internal existing databases, such as the health plan's utilization or prenatal care databases, to identify potential eligible cases or episodes of care not reflected in the health plan's claims/encounter database.

Retro-Eligibility

The HEDIS 2001 Technical Specifications included a new specification of reporting HEDIS measures for members with retroactive enrollment segments. This method was continued for 2002. If a health plan was able to capture the retroactive period, this could be treated as a gap in enrollment. HEDIS auditors cited five health plans that experienced difficulty in capturing the state notification date. Retroactive enrollments are permitted only in the COHS health plans, and two of the health plans that could not capture the state notification date were COHS. For COHS health plans, excluding the months of retroactivity may have improved their final reported rates.

Identification of the Denominator for the Well-Child Visits in the First 15 Months of Life Measure

Within the Medi-Cal managed care program, newborns are usually covered under their mothers' ID number for the month of delivery and month following delivery, up to a maximum of 60 days. Many Medi-Cal managed care plans experienced difficulty in linking the first two months of enrollment with the newly established ID once the child was eligible and enrolled in the plan. This caused the health plans to under-report the denominator. However, the auditors in all circumstances determined that this issue did not materially bias the final reported rate.

Overall Recommendations

Reconsider Global Billing Practices

To improve HEDIS data collection for Women's Care measures, health plans should explore a method of capturing individual dates of services. Health plans could require providers to include each date of service on the global bill, which subsequently would need to be captured by the health plan for use in HEDIS reporting. The health plans could also explore the use of any existing internal database that collects prenatal care visits for use in HEDIS reporting. At a minimum, health plans should re-evaluate procedures in place for global billing to assure that all potential HEDIS data are collected.

Focus Efforts on Improving Data Completeness

More complete claims/encounter data will not only result in higher HEDIS rates, but also will decrease reliance on medical record review, which contributes significantly to the overall cost of collecting data and reporting HEDIS results. Additionally, certain types of payment arrangements with other provider types such as laboratories, hospitals, and vision care providers can have an impact on data completeness. Health plans must be vigilant by routinely monitoring the submission of data and might consider applying some sort of incentive for submitting encounter data.

Health plans should be sure to use all available data sources, including in-house disease management or utilization management databases, and external data sources (e.g., State immunization registries).

Explore the Possibility of Capturing the State Notification Date

Given that NCQA specifications allow health plans to treat retroactive enrollment spans as gaps in enrollment, health plans that do not capture the State notification data should explore their capability to do so. At a minimum, the health plans should attempt to determine if their rates would improve by excluding retroactive enrollment periods. If retroactivity is not frequent for a particular health plan, the impact may be minimal.

Explore Alternative Methods of Linking Mothers to Infants

Health plans that are not able to link mothers to infants and therefore experience difficulties in appropriately identifying the eligible cases for the *Well-Child Visits in the First 15 Months of Life* measure should explore manual processes that could be implemented. Other Medi-Cal managed care plans have successfully implemented processes to link mothers to infant enrollment and claims data.

Introduction

This section contains these appendices:

- APPENDIX A: Limitations
- APPENDIX B: Tabular Results
- APPENDIX C: Audit Designations
- APPENDIX D: Medi-Cal Managed Care Quality Improvement Efforts
- APPENDIX E: Administrative Versus Hybrid Methodology
- APPENDIX F: Glossary of Terms, Acronyms, and Abbreviations

APPENDIX A: Limitations

Limitations of Medical Record Retrieval

- Medi-Cal managed care members tend to be a mobile population. Disruption in Medi-Cal managed care eligibility, monthly open enrollment and disenrollment from health plans, and members that frequently switch PCPs can lead to fragmented medical records. The result is often incomplete or missing medical records rather than a lack of care.
- Services may have been provided in the physician's office, but not documented in the medical record.
- Care may have been rendered outside of the managed care plan's provider network and not recorded at the physician's office (i.e., health fairs, local health departments, schools, and other sites).
- The period of time allotted to health plans and practitioners for medical record retrieval may limit the quality and quantity of data collected.
- The HEDIS 2002 definition of a provided service for some measures (e.g., well-child visits) requires more documentation for medical record review than for administrative data.

The lack of medical record review may indicate: 1) the health plan chose not to pursue medical records; 2) the medical record review was biased, so the health plan could not use the results obtained from medical record review; or 3) the health plan could not locate the medical record or the relevant pieces of the medical record.

Administrative Data Limitations

- Some managed care plans were unable or chose not to use their administrative data due to issues related to data capture and accuracy.
- Providers who are not paid on a fee-for-service basis (e.g., capitated providers) may render services, but may neglect to submit the encounter to the health plan.
- The Data Submission Tool (DST) was limited in its ability to separate the lack of services provided from lack of documented care (i.e., missing medical records).
- Incorrect administrative provider files or the inability to link sample cases with their appropriate providers may have precluded the location of the required medical record documentation.

The lack of administrative data may indicate: 1) the health plan chose to perform 100 percent medical record review; 2) the health plan was unable to perform a system integration with medical record review; or 3) the health plan's administrative data were incomplete and would have produced a biased result.

APPENDIX B: Tabular Results

Table 7-1—Tabular Results—Pediatric Care

	PEDIATRIC CARE								
	Childhood Immunization Status			Well-Child Visits				Adolescent Well-Care Visits	
		Combo 1	Combo 2	First 15 Months		3rd – 6th Years			
Medi-Cal Managed Care Plan	Population	Rate	Rate	Population	Rate	Population	Rate	Population	Rate
Alameda Alliance for Health	1,652	58.5	53.8	302	32.6	7,656	58.6	15,093	40.0
Blue Cross (CP)	5,763	65.3	62.7	681	49.2	26,849	75.0	43,887	36.6
Blue Cross (GMC-North)	2,065	61.1	56.0	291	61.5	8,770	63.0	13,898	27.1
Blue Cross (GMC-South)	287	64.5	62.7	48	37.5	1,120	59.0	1,652	25.5
Blue Cross (Stanislaus)	637	66.7	53.9	29	NA	3,736	54.9	6,494	21.1
Blue Cross (Tulare)	840	69.0	67.1	86	45.3	4,927	65.3	6,063	25.7
CalOptima	6,721	74.7	72.2	8,535	43.8			27,421	43.3
Central Coast Alliance	1,775	60.6	57.7	2,214	42.1			8,821	26.3
Community Health Group	1,384	82.2	79.3	534	44.5	7,948	67.6	12,402	32.6
Contra Costa Health Plan	1,162	69.9	69.2	80	23.8	4,467	57.0	6,835	22.5
Health Net (CP)	15,912	51.9	50.7	2,292	26.0	72,616	55.5	93,544	25.1
Health Net (GMC South)	152	69.5	68.2	46	23.9	669	54.5	1,014	24.9
Health Net (GMC-North)	622	51.3	49.9	133	48.5	2,902	67.4	6,852	29.3
Health Plan of San Joaquin	1,170	47.4	43.6	591	24.9	5,818	65.0	11,370	31.1
Health Plan of San Mateo	754	57.2	56.9	1,108	56.3			2,774	27.8
Inland Empire Health Plan	5,254	68.1	63.0	993	35.2	23,862	62.0	32,007	36.3
Kaiser (GMC-North)	533	69.0	67.0	180	72.2	2,166	46.6	3,776	23.6
Kaiser (GMC-South)	124	65.3	64.5	41	26.8	708	54.9	1,558	25.0
Kern Family Health Care	1,596	63.0	61.8	325	41.5	6,622	66.4	8,353	26.3
L.A. Care Health Plan	24,023	54.6	51.7	1,333	20.0	106970	46.6	128502	16.1
Molina Healthcare (GMC-North)	80	40.0	36.3	36	27.8	1,465	56.7	3,467	34.4
Molina Healthcare of California	1,455	52.1	48.6	426	46.9	7,451	67.5	10,597	39.1
Partnership Healthplan	783	58.1	56.2	573	33.2			6,025	30.3
San Francisco Health Plan	725	66.1	62.9	172	45.3	2,916	63.7	4,337	29.4
Santa Barbara Health Initiative	1,254	74.5	69.2	1,586	62.7			5,274	30.8
Santa Clara Family Health Plan	1,253	63.7	60.4	286	47.6	4,675	67.6	6,441	33.8
Sharp Health Plan	1,274	60.7	59.6	564	41.1	6,025	58.5	6,808	21.2
UCSD Health Plan	306	61.4	60.1	125	27.2	1,346	46.6	2,064	19.2
Universal Care	262	59.5	55.2	47	11.4	1,157	57.7	2,094	17.5
Western Health Advantage	342	45.6	43.6	64	21.9	1,655	53.0	2,910	21.4
2002 Medi-Cal Managed Care Average		62.2	59.2		41.3		59.6		28.2
2002 Medi-Cal Weighted Average		59.6	56.9		41.4		56.4		26.9

Note: The grey boxes indicate that rates were not available for the COHS health plans for this measure. The HEDIS measure *Eye Exams for People with Diabetes* was chosen to replace *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* for the COHS.

Table 7-2—Tabular Results—Women's Care and Living with Illness

Medi-Cal Managed Care Plan	WOMEN'S CARE: Prenatal and Postpartum Care: Timeliness: Population	Timeliness: Rate	Postpartum: Population	Postpartum: Rate	LIVING WITH ILLNESS: Diabetes Care: Eye Exams: Population	Eye Exams: Rate	Asthma Care: Combined Ages: Population	Combined Ages: Rate
Alameda Alliance for Health	1,119	72.0	1,119	59.3			1,770	60.7
Blue Cross (CP)	4,509	80.8	4,509	60.0			5,003	66.5
Blue Cross (GMC-North)	1,559	81.3	1,559	57.9			1,354	57.8
Blue Cross (GMC-South)	229	84.3	229	53.3			149	56.4
Blue Cross (Stanislaus)	464	81.7	464	50.9			757	61.6
Blue Cross (Tulare)	901	85.2	901	63.2			518	62.9
CalOptima	3,084	81.4	3,084	63.3	8,049	59.8	2,820	62.2
Central Coast Alliance	1,332	78.8	1,332	58.4	3,271	61.1	886	54.5
Community Health Group	957	67.6	957	46.0			214	58.4
Contra Costa Health Plan	706	83.7	706	48.0			593	85.3
Health Net (CP)	5,194	55.3	5,194	36.4			3,046	43.2
Health Net (GMC South)	163	47.2	163	28.3			79	50.6
Health Net (GMC-North)	606	63.9	606	47.8			296	55.4
Health Plan of San Joaquin	1,297	75.9	1,297	52.5			818	53.8
Health Plan of San Mateo	789	72.4	789	64.9	2,092	52.9	434	68.9
Inland Empire Health Plan	4,506	71.1	4,506	57.8			2,896	59.4
Kaiser (GMC-North)	415	73.0	415	59.3			504	58.7
Kaiser (GMC-South)	108	84.3	108	57.4			233	44.2
Kern Family Health Care	1,254	71.5	1,254	56.0			581	48.9
L.A. Care Health Plan	4,548	69.9	4,548	45.8			10,680	41.8
Molina Healthcare (GMC-North)	282	64.5	282	39.2			0	NA
Molina Healthcare of California	1,678	67.5	1,678	34.4			660	52.9
Partnership Healthplan	1,164	74.8	1,164	62.2	1,550	55.0	1,158	66.9
San Francisco Health Plan	442	73.0	442	56.1			526	57.8
Santa Barbara Health Initiative	788	88.2	788	76.7	1,913	83.1	633	64.3
Santa Clara Family Health Plan	713	80.8	713	56.6			381	64.0
Sharp Health Plan	1,156	61.6	1,156	56.1			888	56.8
UCSD Health Plan	198	74.2	198	53.0			178	66.9
Universal Care	202	67.5	202	41.5			161	62.7
Western Health Advantage	259	57.4	259	43.4			257	54.5
2002 Medi-Cal Managed Care Average		73.4		53.6		62.0		54.6
2002 Medi-Cal Weighted Average		72.2		52.8		61.4		54.6

Note: The grey boxes indicate that rates were not available for non-COHS health plans for this measure. The HEDIS measure *Eye Exams for people with Diabetes* was chosen to replace *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* for the COHS.

Table 7-3—Tabular Results—Childhood Immunizations and Use of Appropriate Medications for People with Asthma

	Childhood Immunizations							Use of Appropriate Medications for People with Asthma					
								5-9 Years		10-17 Years		18-56 Years	
Medi-Cal Managed Care Plan	Population	DTP Rate	OPV Rate	MMR Rate	HIB Rate	HEP Rate	VZV Rate	Population	Rate	Population	Rate	Population	Rate
Alameda Alliance for Health	1,652	70.9	80.0	85.3	71.8	77.4	74.4	480	55.6	641	63.3	649	61.9
Blue Cross (CP)	5,763	77.8	84.3	88.7	78.7	82.9	82.9	1,249	62.0	1,603	65.4	2,151	69.9
Blue Cross (GMC-North)	2,065	71.3	83.6	88.2	75.7	81.5	79.9	234	44.9	383	50.9	737	65.5
Blue Cross (GMC-South)	287	78.0	84.7	89.2	80.8	81.2	85.7	26	NA	52	48.1	71	64.8
Blue Cross (Stanislaus)	637	78.0	89.6	93.8	81.0	89.6	72.7	131	48.1	205	55.6	421	68.6
Blue Cross (Tulare)	840	81.0	91.0	93.1	78.5	89.1	88.9	148	56.8	163	62.6	207	67.6
CalOptima	6,721	81.7	88.2	88.6	83.8	84.2	84.7	630	49.2	663	63.7	1,527	66.9
Central Coast Alliance	1,775	73.2	79.3	87.6	73.2	76.4	81.8	187	42.8	228	58.3	471	57.3
Community Health Group	1,384	92.7	94.6	94.6	91.7	89.1	90.8	73	57.5	72	52.8	69	65.2
Contra Costa Health Plan	1,162	73.9	80.1	88.4	79.9	78.1	84.6	146	80.8	162	95.1	285	82.1
Health Net (CP)	15,912	63.4	71.1	81.5	65.7	68.1	76.4	830	38.6	1,038	43.1	1,178	46.5
Health Net (GMC South)	152	76.8	88.7	86.8	78.8	78.8	84.1	14	NA	33	42.4	32	53.1
Health Net (GMC-North)	622	61.1	70.2	80.4	65.0	68.1	81.4	46	41.3	72	47.2	178	62.4
Health Plan of San Joaquin	1,170	67.2	79.5	88.8	70.9	75.6	80.2	188	47.3	279	52.3	351	58.4
Health Plan of San Mateo	754	62.5	66.0	69.7	64.1	66.2	66.4	87	59.8	78	61.5	269	74.0
Inland Empire Health Plan	5,254	75.3	83.4	93.1	82.2	71.8	84.3	728	55.6	995	59.2	1,173	61.9
Kaiser (GMC-North)	533	80.9	87.8	87.4	83.3	78.6	85.2	104	51.0	145	55.2	255	63.9
Kaiser (GMC-South)	124	73.4	83.9	94.4	81.5	84.7	87.9	37	40.5	79	38.0	117	49.6
Kern Family Health Care	1,596	73.7	82.5	92.2	80.5	81.5	88.6	148	39.2	175	49.7	258	53.9
L.A. Care Health Plan	24,023	67.1	75.8	79.7	70.0	73.9	73.7	3,666	34.3	3,302	43.7	3,712	47.4
Molina Healthcare (GMC-North)	80	48.8	60.0	75.0	52.5	60.0	66.3	0	NA	0	NA	0	NA
Molina Healthcare of California	1,455	62.5	75.1	85.0	71.5	73.3	77.7	172	44.8	251	50.6	237	61.2
Partnership Healthplan	783	67.4	75.4	77.8	70.0	74.9	75.2	155	62.6	302	65.9	701	68.3
San Francisco Health Plan	725	82.1	84.0	86.3	80.5	82.6	80.7	159	47.2	127	50.4	240	68.8
Santa Barbara Health Initiative	1,254	86.6	94.0	93.8	89.1	88.0	87.0	100	60.0	124	58.9	409	67.0
Santa Clara Family Health Plan	1,253	80.3	88.9	92.1	84.7	77.3	85.4	86	46.5	97	62.9	198	72.2
Sharp Health Plan	1,274	77.5	88.5	92.5	78.6	81.9	89.2	246	53.7	329	60.2	313	55.6
UCSD Health Plan	306	70.3	78.8	91.2	71.6	75.5	86.3	51	52.9	57	68.4	70	75.7
Universal Care	262	68.7	78.8	84.2	71.4	72.2	78.0	36	47.2	55	58.2	70	74.3
Western Health Advantage	342	58.2	71.6	81.3	57.9	73.4	73.1	38	31.6	60	46.7	159	62.9
2002 Medi-Cal Managed Care Average		73.4	81.8	87.2	76.1	78.3	81.3		45.8		54.2		60.2
2002 Medi-Cal Weighted Average		70.9	79.0	84.7	73.7	75.7	78.8		45.8		54.2		60.2

APPENDIX C: Audit Designations

Audit Designations

During the audit process, each health plan received an audit designation for each of the HEDIS measures in the DHS External Accountability Set. The audit designations, based on the rationales defined by NCQA, are presented below.

Table 7-4—HEDIS Audit Designations

Audit Designation	Notation	Rationale
Report	**R**	The health plan followed the specifications and produced a reportable rate for the measure.
Not Report	**NR**	The health plan did not calculate the rate, the rate was materially biased, or the health plan chose not to report the rate.

Health plans that received an "NR" were not included in the calculation of the overall Medi-Cal managed care average for a given measure.

Individual HEDIS measures may have been calculated correctly, but may still contain fewer than 30 cases in the denominator. In these cases, the rate for the measure would be "NA," but the audit designation would be "R."

Table 7-5—Audit Designations—Pediatric Care

Medi-Cal Managed Care Plan	PEDIATRIC CARE								
	Childhood Immunizations			Well-Child Visits				Adolescent Well-Care Visits	
		Combo 1	Combo 2	First 15 Months		3rd - 6th Years			
	Population	Rate	Rate	Population	Rate	Population	Rate	Population	Rate
Alameda Alliance for Health	1,652	R	R	302	R	7,656	R	15,093	R
Blue Cross (CP)	5,763	R	R	681	R	26,849	R	43,887	R
Blue Cross (GMC-North)	2,065	R	R	291	R	8,770	R	13,898	R
Blue Cross (GMC-South)	287	R	R	48	R	1,120	R	1,652	R
Blue Cross (Stanislaus)	637	R	R	29	NA	3,736	R	6,494	R
Blue Cross (Tulare)	840	R	R	86	R	4,927	R	6,063	R
CalOptima	6,721	R	R	8,535	R			27,421	R
Central Coast Alliance	1,775	R	R	2,214	R			8,821	R
Community Health Group	1,384	R	R	534	R	7,948	R	12,402	R
Contra Costa Health Plan	1,162	R	R	80	R	4,467	R	6,835	R
Health Net (CP)	15,912	R	R	2,292	R	72,616	R	93,544	R
Health Net (GMC South)	152	R	R	46	R	669	R	1,014	R
Health Net (GMC-North)	622	R	R	133	R	2,902	R	6,852	R
Health Plan of San Joaquin	1,170	R	R	591	R	5,818	R	11,370	R
Health Plan of San Mateo	754	R	R	1,108	R			2,774	R
Inland Empire Health Plan	5,254	R	R	993	R	23,862	R	32,007	R
Kaiser (GMC-North)	533	R	R	180	R	2,166	R	3,776	R
Kaiser (GMC-South)	124	R	R	41	R	708	R	1,558	R
Kern Family Health Care	1,596	R	R	325	R	6,622	R	8,353	R
L.A. Care Health Plan	24,023	R	R	1,333	R	106970	R	128502	R
Molina Healthcare (GMC-North)	80	R	R	36	R	1,465	R	3,467	R
Molina Healthcare of California	1,455	R	R	426	R	7,451	R	10,597	R
Partnership Healthplan	783	R	R	573	R			6,025	R
San Francisco Health Plan	725	R	R	172	R	2,916	R	4,337	R
Santa Barbara Health Initiative	1,254	R	R	1,586	R			5,274	R
Santa Clara Family Health Plan	1,253	R	R	286	R	4,675	R	6,441	R
Sharp Health Plan	1,274	R	R	564	R	6,025	R	6,808	R
UCSD Health Plan	306	R	R	125	R	1,346	R	2,064	R
Universal Care	262	R	R	47	R	1,157	R	2,094	R
Western Health Advantage	342	R	R	64	R	1,655	R	2,910	R

Note: The grey boxes indicate that rates were not available for the COHS health plans for this measure. The HEDIS measure *Eye Exams for People with Diabetes* was chosen to replace *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* for the COHS.

Table 7-6—Audit Designations—Women's Care and Living with Illness

Medi-Cal Managed Care Plan	WOMEN'S CARE				LIVING WITH ILLNESS			
	Prenatal and Postpartum Care				Diabetes Care		Asthma Care	
	Timeliness		Postpartum		Eye Exams		Combined Ages	
	Population	Rate	Population	Rate	Population	Rate	Population	Rate
Alameda Alliance for Health	1,119	R	1,119	R			1,770	R
Blue Cross (CP)	4,509	R	4,509	R			5,003	R
Blue Cross (GMC-North)	1,559	R	1,559	R			1,354	R
Blue Cross (GMC-South)	229	R	229	R			149	R
Blue Cross (Stanislaus)	464	R	464	R			757	R
Blue Cross (Tulare)	901	R	901	R			518	R
CalOptima	3,084	R	3,084	R	8,049	R	2,820	R
Central Coast Alliance	1,332	R	1,332	R	3,271	R	886	R
Community Health Group	957	R	957	R			214	R
Contra Costa Health Plan	706	R	706	R			593	R
Health Net (CP)	5,194	R	5,194	R			3,046	R
Health Net (GMC South)	163	R	163	R			79	R
Health Net (GMC-North)	606	R	606	R			296	R
Health Plan of San Joaquin	1,297	R	1,297	R			818	R
Health Plan of San Mateo	789	R	789	R	2,092	R	434	R
Inland Empire Health Plan	4,506	R	4,506	R			2,896	R
Kaiser (GMC-North)	415	R	415	R			504	R
Kaiser (GMC-South)	108	R	108	R			233	R
Kern Family Health Care	1,254	R	1,254	R			581	R
L.A. Care Health Plan	4,548	R	4,548	R			10,680	R
Molina Healthcare (GMC-North)	282	R	282	R			0	NA
Molina Healthcare of California	1,678	R	1,678	R			660	R
Partnership Healthplan	1,164	R	1,164	R	1,550	R	1,158	R
San Francisco Health Plan	442	R	442	R			526	R
Santa Barbara Health Initiative	788	R	788	R	1,913	R	633	R
Santa Clara Family Health Plan	713	R	713	R			381	R
Sharp Health Plan	1,156	R	1,156	R			888	R
UCSD Health Plan	198	R	198	R			178	R
Universal Care	202	R	202	R			161	R
Western Health Advantage	259	R	259	R			257	R

Note: The grey boxes indicate that rates were not available for non-COHS health plans for this measure. The HEDIS measure *Eye Exams for people with Diabetes* was chosen to replace *Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life* for the COHS.

APPENDIX D: Medi-Cal Managed Care Plan Quality Improvement Efforts

Table 7-7—Quality Improvement Efforts for Childhood Immunization Status (Combination 1)

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Childhood Immunizations
	2000	2001	2002	
Childhood Immunizations Combination 1 HPL = 69.3 MPL = 41.8				
Blue Cross (Tulare)	NA	54.4	69.0	Immunization reminder cards to parents of children at age 2, 4, 6, 12, and 15 months of age. Monthly notification to PCPs of members age 9 and 18 months of age that are not up to date with immunizations. Monthly faxes to PCPs identifying members age 9 and 18 months of age who are not up to date with immunizations. For members not updated via PCP fax, the Outreach Call Center phones members for immunization status and offers encouragement to visit PCP. RN visits the office for PCPs that do not respond to the monthly faxes to evaluate/educate/assist with reminder/recall systems in PCP office.
(Stanislaus)	57.4	61.1	66.7	
(GMC-South)	NA	45.0	64.5	
Community Health Group	54.0	60.1	82.2 Above HPL	Increased provider education. Improved process for collecting encounter data, including providing incentives to providers.
Contra Costa Health Plan	62.3	70.3 Above HPL	69.9 Above HPL	Contra Costa Health Plan received the registry data and downloaded it into its HEDIS warehouse. The plan also built a user interface from its claims payment system to the registry. Immunizations that came in on the PM-160 form were used to update the immunization registry. The registry was then used to send automatic reminders to parents for immunizations. Childhood Immunizations were also the focus of one of the IQIPs for Contra Costa Health Plan.
Kaiser (GMC-North)	58.9	70.3 Above HPL	69.0	The frequency of childhood immunization outreach was increased from quarterly to six times per year. Lists of children needing immunizations were sent to the facility contacts every two months. Facilities used the list to contact parents. Whenever a member came to a facility, needed services, including immunizations, were printed directly on the intake form.
L.A. Care Health Plan	46.4	54.8	54.6	L.A. Care Health Plan has contracts with several other plans to provide services to its members. L.A. Care Health Plan worked to improve the encounter data submission from its plan partners by providing financial incentives.
Molina Healthcare of California	39.7 Below MPL	53.6	52.1	A welcome call was conducted for every managed care member and the member was assisted with getting an appointment to see a primary care practitioner. Gifts certificates were issued for children who had all their immunizations. Data collection process was improved.

Table 7-7—Quality Improvement Efforts for Childhood Immunization Status (Combination 1) (continued)

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Childhood Immunizations
	2000	2001	2002	
Partnership Healthplan	49.5	58.8	58.1	Conducted some provider education. Published HEDIS rates in the newsletter for both members and providers and shared best practices.
San Francisco Health Plan	55.6	57.4	66.1	Sent packages to 15 pediatric provider sites containing lists of children ages 6, 12, 15, and 18 months of age for immunizations. Bilingual post cards were given to the providers to send out to the parents, and San Francisco Health Plan also sent out reminder cards to the same age group of children.
Santa Clara Family Health Plan	52.1	61.0	63.7	Started sending postcards to parents for children at 12 and 18 months of age. Obtained immunization registry data. Intensified pursuit of medical records.
Sharp Health Plan	27.6 Below MPL	45.8	60.7	Increased provider education and improved encounter data submission. Sent newsletter discussing importance of HEDIS and the need for managed care members to get recommended services. Reminder post sent bi-annually.
UCSD Health Plan	NA	34.2 Below MPL	61.4	Improved database management and programming was improved to capture all child immunizations. Obtained additional immunization history from County Registry, if not found in health plan database or medical records. Educated providers at "Provider Workshops" two to four times a year and sent out provider newsletter discussing areas for improvement. Sent out member newsletter discussing importance of immunizations.

Table 7-8—Quality Improvement Efforts for Well-Child Visits in the First 15 Months of Life (Six or More Visits)

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Well-Child Visits in the First 15 Months of Life
	2000	2001	2002	
Well-Child Visits in the First 15 Months of Life HPL = 57.9 MPL = 18.1				
Blue Cross (GMC-North) (Tulare)	53.6 NA	52.4 10.4 Below MPL	61.5 45.3	Well-Child visit reminder cards sent to parents of children at age 2, 4, 6, 12, and 15 months of age.
Community Health Group	0.0 Below MPL	25.2	44.5	Increased provider education. Improved process for collecting encounter data, including providing incentives to providers. Sent reminders to members and PCPs for Well Child Visits
Partnership Health Plan	21.6	32.6	33.2	Conducted some provider education. Published HEDIS rates in the newsletter for both members and providers and shared best practices.
Santa Clara Family Health Plan	27.1	27.0	47.6	Case Manager calls mothers who have delivered and reminds them to get Well Baby Visits and sign up for Medi-Cal.

Table 7-9—Quality Improvement Efforts for Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life
	2000	2001	2002	
Well-Child Visits in the Third, Fourth, Fifth and Sixth Year of Life HPL = 68.2 MPL = 38.9				
Blue Cross				Well-Child visit reminder cards sent to parents of children at age 2, 4, 6, 12, and 15 months of age.
(GMC-North)	56.6	56.3	63.0	
(GMC-South)	49.1	49.9	59.0	
(CP)	65.5	62.5	75.0 Above HPL	
(Stanislaus)	47.2	54.1	54.9	
(Tulare)	NA	57.4	65.3	
Community Health Group	58.6	66.9	67.6	Rate increase was thought to be the result of increased provider education and improved processes for collecting encounter data, including providing incentives to providers. Sent mail to PCPs and members to remind them of needed well-child visits.
Inland Empire Health Plan	52.0	61.1	62.0	Created a provider incentive program that gave providers additional fees for well-child visits, but required submission of an encounter form.
Universal Care	43.1	51.6	57.7	Universal Care had a substantial increase in administrative data for well-child visits (113 administrative positive cases in 2001 verses only 49 in 2000). This indicates better encounter data submission for this type of service.

Table 7-10—Quality Improvement Efforts for Adolescent Well-Care Visits

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Adolescent Well-Care Visits
	2000	2001	2002	
Adolescent Well Care Visits HPL = 44.4 MPL = 19.3				
Alameda Alliance for Health	34.5	32.9	40.0	Began paying providers on a fee-for-service basis in addition to the providers' capitation to improve data reporting.

Table 7-11—Quality Improvement Efforts for Eye Exams for People with Diabetes

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Eye Exams for People with Diabetes
	2000	2001	2002	
Eye Exams for People With Diabetes HPL = 61.1 MPL = 26.6				
Santa Barbara Health Initiative	68.7 Above HPL	75.4 Above HPL	83.1 Above HPL	Reports were sent to the high volume providers each month showing rates for the various HEDIS indicators for diabetes. A nurse in charge of this process then met with low performing providers on a quarterly basis. Financial incentives were given to providers for completing tests on diabetic members and for showing improvement in outcomes, such as lower HbA1c levels in these members. Diabetes was also an IQIP for Santa Barbara Health Initiative.
Central Coast Alliance	29.4	54.5	61.1 Above HPL	Increased experience for collecting and reporting HEDIS data. Increased staff, including creating a Quality Improvement manager position. Lists sent to providers of diabetic members due for an eye exam and reminders sent to members.

Table 7-12—Quality Improvement Efforts for Timeliness of Prenatal Care

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Timeliness of Prenatal Care
	2000	2001	2002	
Timeliness of Prenatal Care HPL = 79.5 MPL = 46.0				
Blue Cross (Tulare)	NA	65.7	85.2 Above HPL	Trimester mailings to members including educational materials, breastfeeding information, community based referrals/classes, immunization cards, and a gift. Health Education department assists members with community class enrollment. Referrals are sent to Case Management for high-risk members. Customer Care Center was instructed to offer program enrollment to all women within childbearing age.
L.A. Care Health Plan	NA	58.7	69.9	Collected more data through incentive programs for data submission.

Table 7-13—Quality Improvement Efforts for Postpartum Care Visits

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Postpartum Care Visits
	2000	2001	2002	
Postpartum Care HPL = 61.0 MPL = 34.5				
Santa Barbara Health Initiative	71.4 Above HPL	74.9 Above HPL	76.7 Above HPL	Utilization Management identified pregnant members for monitoring purposes. The hospitals notified Santa Barbara Health Initiative when a member was admitted, and a nurse from the plan went to the hospital to meet with the mother and discuss postpartum care. Postcards with the actual date range of when a postpartum visit was needed were then sent to the member and their provider as a reminder.
CalOptima	44.5	52.7	63.3 Above HPL	The CalOptima Prenatal Support Service staff designed a form that included all elements necessary for documentation of a positive postpartum exam. The forms were distributed to OB physician offices. Providers and office staff were educated on HEDIS standards. The plan started an incentive program (gift certificates) for women who had postpartum care visits. CalOptima mailed a letter to all pregnant women in the third trimester educating them on the importance of the postpartum exam. A coupon was enclosed that had to be signed by a physician indicating the exam was completed and returned to CalOptima, at which time a gift certificate was mailed to the member. A reminder letter was also designed for the provider offices. The letter gave the member the date of the scheduled postpartum appointment and advised the importance of keeping the appointment. Prior results showed a written reminder worked better than phone calls.
Inland Empire Health Plan	40.7	50.0	57.8	In December 2000, Inland Empire Health Plan started a High Risk OB Program. Nearly 75 percent of all pregnant women enrolled in Inland Empire Health Plan qualified for this outreach program.
Blue Cross (GMC-South)	41.4	48.9	53.3	There was a prenatal outreach program in place and an IQIP on Breastfeeding that may have contributed to the increase in the rate. However, 2001 was the second year of reporting HEDIS for the Blue Cross (GMC-South) contract. The increase in rates was also attributed to increased experience with collecting and reporting on the HEDIS measures.
Community Health Group	34.8	46.7	46.0	Increased provider education. Improved process for collecting encounter data, including providing incentives to providers.
Contra Costa Health Plan	33.0 Below MPL	45.7	48.0	Began using the hybrid method to report postpartum visits.

Table 7-13—Quality Improvement Efforts for Postpartum Care Visits (continued)

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts For Postpartum Care Visits
	2000	2001	2002	
Sharp Health Plan	20.2 Below MPL	34.2 Below MPL	56.1	Increased provider education and improved encounter data submission. Sent newsletter to members discussing importance of HEDIS and the need for members to get recommended services. Member contacted by phone and mailed a prenatal packet.
Molina Healthcare of California	15.3 Below MPL	26.2 Below MPL	34.4 Below MPL	Started a "Motherhood Matters" program. All pregnant members were given a car seat and were eligible to receive gifts. Improved data collection process.
Alameda Alliance for Health	42.9	40.9	59.3	High volume OB providers were given (1) an incentive to provide postpartum care during HEDIS time period, and (2) a schedule of when visits should be performed based on delivery date for each patient. Health Plan purchased approved NCQA software for calculating HEDIS administrative rates.

Table 7-14—Quality Improvement Efforts for Use of Appropriate Medications for People with Asthma (Combined Rate)

Medi-Cal Managed Care Plan	HEDIS Rate			Quality Improvement Efforts Use of Appropriate Medications for People with Asthma
	2000	2001	2002	
Use of Appropriate Medications for People With Asthma HPL = 64.9 MPL = 44.9				
Contra Costa Health Plan	NA	49.6	85.3 Above MPL	Obtain asthma patient lists from emergency rooms and enter patients into a case management program. Case manager telephones or visits patients and provide education on managing their asthma and how to remediate asthma triggers in their environment. HP, also, believes reporting improved from previous year.
Blue Cross (CP)	NA	56.0	66.5 Above MPL	Distributed Asthma Clinical Practice Guidelines to PCPs. Faxed to PCP identifying asthmatic members and requested confirmation of diagnosis. Conducted one-on-one member/pharmacist consultation. Distributed asthma kits including: peak flow meter, spacers, asthma diary, and educational materials. Sent quarterly newsletter to members in program.
(Stanislaus)	NA	54.9	61.6	
(GMC-North)	NA	49.2	57.8	
(GMC-South)	NA	50.7	56.4	

APPENDIX E: Administrative Versus Hybrid Methodology

For each measure in this report there is a figure showing how much of the final rate for each Medi-Cal managed care plan was derived from administrative data and how much was derived from medical record review.

Administrative Methodology

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. In addition, the numerator(s), or services provided to the members in the eligible population, are derived solely from administrative data. Medical records cannot be used to retrieve information. When using the administrative method the entire eligible population becomes the denominator, and sampling is not allowed.

The administrative method is cost efficient; but, if done exclusively, this method can produce lower rates due to a number of reasons such as incomplete data submissions from capitated providers.

HEDIS technical specifications require that selected measures, such as the *Use of Appropriate Medications for People with Asthma* measure, be reported using only the administrative method.

Hybrid Methodology

The hybrid method requires health plans to identify the eligible population using administrative data, and then extract a systematic sample of members from the eligible population, which becomes the denominator. Administrative data is then used to identify services provided to those members. Medical records are reviewed for those members who do not have evidence of a service or of a qualified exclusion identified using administrative data.

The hybrid method generally produces higher rates, but is considerably more labor intensive.

APPENDIX F: Glossary of Terms, Acronyms, and Abbreviations

~A~

AAP

American Academy of Pediatrics.

ACIP

Advisory Committee on Immunization Practices.

Administrative Data

Any automated data within a health plan (e.g., claims/encounter data, member data, provider data, hospital billing data, pharmacy data and laboratory data).

Administrative Method

The administrative method requires health plans to identify the eligible population (i.e., the denominator) using administrative data. The numerator(s), or services provided to the members who are in the eligible population, are solely derived from administrative data.

Medical records cannot be used to retrieve information. When using the administrative method the entire eligible population becomes the denominator, and sampling is not allowed. The administrative method is cost efficient, but can produce lower rates due to incomplete data submission by capitated providers. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to use the administrative method and finds that 4,000 members out of the 10,000 had evidence of a postpartum visit using administrative data. The final rate for this measure, using the administrative method, would therefore be 4,000/10,000 or 40 percent.

AMA

American Medical Association.

Audit Designation

The auditor's final determination, based on audit findings, of the appropriateness of the health plan publicly reporting its HEDIS measure rates.

Each measure, included in the HEDIS audit, receives either a "*Report"* designation or a *"Not Report"* designation, along with the rationale for why the measure received that particular designation.

~B~

Baseline Assessment Tool (BAT) Review

The BAT, completed by each health plan undergoing the HEDIS audit process, provides information to auditors regarding the health plan's systems for collecting and processing data for HEDIS reporting.

Auditors review the BAT prior to the scheduled on-site health plan visit to gather preliminary information for: planning/targeting on-site visit assessment activities; determining the core set of measures to be reviewed; determining which hybrid measures will be included in medical record validation; requesting core measures source code, as needed; identifying areas that require additional clarification during the on-site visit; and determining whether the core set of measures needs to be expanded.

Bias

A deviation of the results from the truth. (e.g., rates that are substantially biased do not represent the eligible population and, therefore, inferences about the population cannot be made).

For example, rates that are substantially biased do not represent the eligible population and, therefore, inferences about the population cannot be made.

~C~

CAHPS® 2.0H

Consumer Assessment of Health Plans Survey (CAHPS) 2.0H is a set of standardized surveys that assess patient satisfaction with experience of care.

Capitation

A method of payment for providers.

Under a capitated payment arrangement, providers are reimbursed on a per member/per month basis. The provider receives payment each month, regardless of whether the member needed services or not. Therefore, there is little incentive for providers to submit individual encounters, knowing that payment is not dependent on such submission.

CDC

Centers for Disease Control and Prevention.

COHS

County Organized Health System. In California a COHS is an agency organized and operated by the county with representation from providers, members, local government and other interested parties. A COHS contracts with the Medi-Cal managed care program to cover virtually all the Medi-Cal beneficiaries within the county. Members have a wide choice of managed care providers, but do not have the option of obtaining services under the fee-for-service system unless authorized by the health plan.

Certified HEDIS® Software Vendor

A third party, whose source code has been certified by NCQA, that contracts with a health plan to write source code for HEDIS measures. For a vendor's software to be certified by NCQA, all of the vendor's programmed HEDIS measures must be submitted to NCQA for automated testing of program logic, and a minimum of 70 percent of the measures must receive a *"Pass"* or *"Pass with Qualifications"* designation.

Claims Based Denominator

When the eligible population for a measure is obtained from claims data.

For claims-based denominator hybrid measures, health plans must identify their eligible population and draw their sample no earlier than January of the year following the measurement year to ensure all claims incurred through December 31 of the measurement year are captured in their system.

CMS (formerly known as HCFA)

The Centers for Medicare & Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), provides health insurance to individuals through Medicare, Medicaid, and the State Children's Health Insurance Program (SCHIP).

CMS regulates laboratory testing through Clinical Laboratory Improvement Amendments (CLIA), develops coverage policies, and initiates quality of care improvement activities. CMS maintains oversight of nursing homes and continuing care providers, including home health agencies, intermediate care facilities for the mentally retarded, and hospitals.

Computer Logic

Programmed, step-by-step sequence of instructions to perform a given task.

Continuous Enrollment Requirement

The minimum amount of time that a member must be enrolled in a health plan to be eligible for inclusion in a measure to ensure that the health plan has a sufficient amount of time to be held accountable for providing services to that member.

Core Set Selection

For a full HEDIS audit, the process that auditors follow to select the core set of measures to be reviewed in detail during the audit process.

CP

Commercial Plans. See Two-Plan Model.

CPT

Current Procedural Terminology (CPT ™) is a listing of billing codes used to document the provision of medical services and procedures.

~D~

Data Completeness

The degree to which actually occurring services/diagnoses appear in the health plan's administrative data systems.

Data Completeness Study

An internal assessment developed and performed by a health plan, using a statistically sound methodology, to quantify the degree to which actually occurring services/diagnoses appear or do not appear in the health plan's administrative data systems.

Denominator

The number of members who meet all criteria specified in the measure for inclusion in the eligible population.

When using the administrative method, the entire eligible population becomes the denominator. When using the hybrid method, a sample of the eligible population becomes the denominator.

DHS

California Department of Health Services.

DHS External Accountability Set

A set of performance measures representing the areas of clinical quality that are appropriate to the Medi-Cal managed care population.

In 2001, all DHS External Accountability Set measures were HEDIS measures. Three of these measures (i.e., *Childhood Immunization Status*, *Use of Appropriate Medications for People with Asthma*, and *Eye Exams for People with Diabetes*) evaluate effectiveness of care provided to members enrolled in the Medi-Cal managed care plans. *Timeliness of Prenatal Care* and *Postpartum Care* assess whether or not care is provided to members in a timely manner. *Well-Child Visits* and *Adolescent Well-Care Visits* assess the percentage of members who are receiving recommended services.

DRG Coding

Diagnostic-related Group (DRG) coding sorts diagnoses and procedures by groups under major diagnostic categories with defined reimbursement limits.

DST

Data Submission Tool.

The tool used to report HEDIS data to NCQA.

DtaP

Diphtheria, tetanus, and acellular pertussis vaccine.

DTP or DTaP

Diphtheria, tetanus, and pertussis vaccine.

~E~

EDI

Electronic Data Interchange (EDI) is the direct computer-to-computer transfer of data.

Electronic Data

Data that are maintained in a computer environment vs. a paper environment.

Encounter Data

Billing data received from a capitated provider.

Although the managed care plan does not reimburse the provider for each individual encounter, submission of the encounter data to the plan allows the plan to collect the data for future HEDIS reporting.

EQRO

External quality review organization. Health Services Advisory Group is the EQRO for California DHS.

Exclusions

Conditions outlined in HEDIS measure specifications that describe when a member should not be included in the denominator.

~F~

FACCT

The Foundation for Accountability is a not-for-profit organization that helps consumers understand health care quality, and compare health plan and provider performance.

Fee-for-Service

A reimbursement mechanism where the provider gets paid for services billed.

Final Report

Following the health plan's completion of any corrective actions, the written report that is completed by the auditor documenting all final findings and results of the HEDIS audit.

The final report includes the Summary Report, IS capabilities Assessment, Medical Record Review Validation Findings, Measure Designations and Audit Opinion (Final Audit Statement).

Full HEDIS® Audit

A full audit occurs when the HEDIS auditor selects a sample of measures (core set) that represent all HEDIS domains of care and extrapolates the findings on that sample to the entire set of HEDIS measures.

Health plans that undergo a full audit can use the NCQA seal in marketing materials.

~G~

Global Billing Practices

The practice of billing multiple services provided over a period of time in one inclusive bill, commonly used by OB providers to bill prenatal and postpartum care.

GMC

Geographic Managed Care health plans. DHS contracts with multiple health plans to cover the entire TANF-linked population in the county on a mandatory enrollment basis. Beneficiaries have the option to choose from multiple commercial managed care plans for health care services. For the purposes of this report, the Sacramento GMC health plans are referred to as GMC-North; San Diego plans are referred to as GMC-South. Health Net, Kaiser Foundation Health Plan and Blue Cross of California have contracts in both Sacramento and San Diego. These plans are referred to in this report as: Health net (GMC-North), Health Net (GMC-South), Kaiser (GMC-North), Kaiser (GMC-South), Blue Cross (GMC-North) and Blue Cross (GMC-South).

~H~

HCFA 1500

A type of claim form used to bill professional services.

HEDIS®

The Health Plan Employer Data and Information Set (HEDIS), developed and maintained by NCQA, is a set of performance measures used to assess the quality of care provided by managed health care organizations.

HEDIS® Measure Determination Standards (HD)

The standards that auditors use during the audit process to assess a health plan's adherence to HEDIS measure specifications.

HEDIS Repository

The data warehouse where all data used for HEDIS reporting are stored.

HEDIS Warehouse

See HEDIS Repository.

HiB

Haemophilus influenza Type B vaccine.

HPL

High Performance Level.

The HPL is set by DHS and is defined as the NCQA 2000 national Medicaid 90th percentile for each measure. If the 90th percentile was not available, then the Medi-Cal managed care average plus one standard deviation was used.

HSAG

Health Services Advisory Group, Inc.

Hybrid Measures

Measures that can be reported using the hybrid methodology.

Hybrid Methodology

The hybrid method requires health plans to identify the eligible population using administrative data, and then extract a systematic sample of 411 members from the eligible population, which becomes the denominator. Administrative data is then used to identify services provided to those 411 members. Medical records must then be reviewed for those members who do not have evidence of a service being provided using administrative data.

The hybrid method generally produces higher results, but is considerably more labor intensive. For example, a health plan has 10,000 members who qualify for the *Prenatal and Postpartum Care* measure. The health plan chooses to use the hybrid method. After randomly selecting 411 eligible members, the health plan finds that 161 members had evidence of a postpartum visit using administrative data. The health plan then obtains and reviews medical records for the 250 members who did not have evidence of a postpartum visit using administrative data. Of those 250 members, 54 were found to have a postpartum visit recorded in the medical record. The final rate for this measure, using the hybrid method, would therefore be (161 + 54) /411, or 52 percent.

~I~

ICD-9-CM

ICD-9-CM, the acronym for the International Classification of Diseases, 9th Revision, Clinical Modification, is the statistical classification of diseases and injuries into groups according to established criteria that is used for billing purposes.

Inpatient Data

Data derived from an inpatient hospital stay.

Inter-Rater Reliability

For the purpose of this report, the inter-rater reliability was a measurement of the agreement rate between the audit firm's abstraction and the Medi-Cal managed care plan's abstraction of the medical record data.

IPV

Inactivated poliovirus vaccine.

IS

Information System.

An automated system for collecting, processing and transmitting data.

IT

Information Technology.

The technology used to create, store, exchange, and use information in its various forms.

~J K~

Key Data Elements

The data elements that must be captured to be able to report HEDIS measures.

~L~

LI

Local Initiative. See Two-Plan Model.

Logic Checks

Evaluations of programming logic to determine its accuracy.

~M~

Manual Data Collection

Collection of data through a paper versus an automated process.

Mapping Codes
The process of translating a health plan's propriety or nonstandard billing codes to industry standard codes specified in HEDIS measures.
Mapping documentation should include a crosswalk of relevant codes, descriptions and clinical information, as well as the policies and procedures for implementing the codes.
Material Bias
For measures reported as a rate, any error that causes a (+/-) five percent difference in the reported rate.
MCO
Managed Care Organization.
Medical Record Validation
The process that auditors follow to verify that the health plan's medical record abstraction proofs meets industry standards, and the abstracted data are accurate.
Medicaid Benchmarks
The NCQA national average for each HEDIS measure for the Medicaid product line, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.
Member Data
Electronic health plan files containing information about members, such as name, date of birth, gender, current address, and enrollment (i.e., when the member joined the health plan).
MPL
Minimum Performance Level.
The MPL is set by DHS and is defined as the NCQA 2000 national Medicaid 25th percentile for each measure. If the 25th percentile was not available, then the Medi-Cal managed care average minus one standard deviation was used.
Modifier Codes
Two-digit or five-digit extensions added to CPT™ codes to provide additional information about services/procedures.
MMR
Measles, mumps, rubella vaccine.

~N~

NA

Not Applicable.

The health plan did not offer the benefit or the denominator was too small (i.e. less than 30) to report a valid rate, the result/rate is NA.

National Benchmarks

The NCQA national average for each HEDIS measure, used to compare health plan performance and assess the reliability of a health plan's HEDIS rates.

NCQA

National Committee for Quality Assurance.

NCQA is a not-for-profit organization that assesses, through accreditation reviews and standardized measures, the quality of care provided by managed health care delivery systems; reports results of those assessments to employers, consumers, public purchasers, and regulators; and ultimately seeks to improve the health care provided within the managed care industry.

NDC

National Drug Codes.

These codes are used for billing pharmacy services.

NR

Not Report HEDIS audit designation.

There are three reasons a measure may be designated NR: 1) the health plan did not calculate the measure and a population existed for which the measure could have been calculated, 2) the health plan calculated the measure but chose not to report the result, or 3) the health plan calculated the measure but the result was materially biased.

Numerator

The number of members in the denominator who received all the services as specified in the measure.

~O~

OPV

Oral polio vaccine.

Over-Read Process

The process of re-reviewing a sample of medical records by a different abstractor to assess the degree of agreement between two different abstractors and ensure the accuracy of abstracted data.

The over-read process should be conducted by the health plan as part of its medical record review process, and auditors over-read a sample of the health plan's medical records as part of the audit process.

~P~

Partial HEDIS Audit

A partial audit occurs when the health plan, state regulator, or purchaser selects the HEDIS measures for audit.

There may be any number of measures selected, but unlike a full audit, findings are not extrapolated to the entire set of HEDIS measures. In addition, the health plan cannot use the NCQA seal in marketing materials.

Pharmacy Data

Data derived from the provision of pharmacy services.

Primary Source Verification

The practice of reviewing the processes and procedures, to input, transmit and track data from its originating source to the HEDIS repository, to verify that the originating information matches the output information for HEDIS reporting.

Proprietary Codes

Unique billing codes developed by a health plan, which have to be mapped to industry standard codes for HEDIS reporting.

Provider Data

Electronic files containing information about physicians, such as type of physician, specialty, reimbursement arrangement, and office location.

~Q R~

Retroactive Enrollment

The effective date of a member's enrollment in a health plan occurs prior to the date that the health plan is notified of that member's enrollment.

Medicaid members who are retroactively enrolled in a health plan must be excluded from a HEDIS measure denominator if the time period from the date of enrollment to the date of notification exceeds the measure's allowable gap specifications.

Revenue Codes

Billing codes used to identify services, procedures, supplies, or materials.

~S~

Sample Frame

In the hybrid method, the eligible population who meet all criteria specified in the measure, from which the systematic sample is drawn.

Source Code

The written computer programming logic for determining the eligible population and denominators/numerators and calculating the rate for each measure.

Software Vendor

A third party that contracts with a managed care plan to write source code and calculate the HEDIS rates.

Standard Codes

Industry standard billing codes such as, ICD-9-CM, CPT™, DRG, Revenue, and UB92 codes used for billing inpatient and outpatient health care services.

Studies on Data Completeness

Studies that health plans conduct to assess data completeness.

Systematic Sampling Routine

The procedure required by NCQA for selecting the sample cases from the eligible member population.

Systematic sampling is performed by alphabetically sorting the eligible members for each measure and then selecting members from the list at specific intervals, such as every seventh member on the list.

~T~

TANF

Temporary Assistance to Needy Families.

T-test Validation

A statistical validation of a health plan's positive medical record numerator events.

Two-Plan Model

The Two-Plan Model is the principal Medi-Cal managed care model in California. In each county designated for this model, two health plans cover the entire TANF-linked population in the county. DHS contracts with one locally developed comprehensive managed care system, called a Local Initiative (LI) and one Commercial Plan (CP).

~U~

UB 92 Claims

A type of claim form used to bill hospital-based inpatient, outpatient, emergency room, and clinic drugs, supplies, and/or services.

UB-92 codes are primarily Type of Bill and Revenue codes.

~V W X Y Z~

Vendor

Any third party that contracts with a health plan to perform services.

The most common delegated services are: pharmacy vendors, vision care services, laboratory services, claims processing, HEDIS software vendors, and provider credentialing.

VZV

Varicella -zoster virus (chicken pox) vaccine.